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An Approach to the Teaching of Psychiatric Nursing in Diploma and Associate Degree Programs: A Method for Content Integration and Course Development in the Curriculum.

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This report is for use by nurse educators concerned with curriculum development and by nursing service personnel wishing to provide quality care. Eight diploma schools and eight associate-degree programs were chosen to participate in the project as testing centers for the methods and materials. Content and learning experiences in psychiatric/mental-health nursing were assessed by questionnaire and interview. Definitions and expected competence were stated for the general practice of nursing, nurse-patient relationships, communication skill, therapeutic environment, community aspects, and work with patient groups, nursing teams, and interdisciplinary teams. To achieve this competence, the course content had to be identified, levels of progression determined, and related course content planned. Learning experiences and evaluation methods were devised concurrently. Planning for integration of psychiatric/mental-health nursing content in the curriculum and for the course in nursing care of the mentally ill included three concepts: (1) man in relation to himself (dynamics of individual behavior); (2) man in relation to others (dynamics of communication); and (3) man in relation to the environment (dynamics of environmental influences). Appendixes include a full explanation of these concepts, bibliography, definitions, participating programs, and a list of the consultants for the project. (HH)

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NATIONAL LEAGUE FOR NURSING

1968

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AN APPROACH TO THE TEACHING OF PSYCHIATRIC NURSING IN DIPLOMA AND ASSOCIATE DEGREE PROGRAMS:

A METHOD FOR CONTENT INTEGRATION AND COURSE DEVELOPMENT IN THE CURRICULUM

Joan E. Walsh, Project Director and Principal Investigator
and
Cecelia Monat Taylor, Assistant Project Director and Consultant

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Other Publications from the Project

Teaching Psychiatric Nursing in Diploma and Associate Degree Programs, by Joan E. Walsh, Nursing Outlook, June, 1967.

Expected Competencies as a Basis for Selecting Content in Psychiatric Nursing, by Joan E. Walsh and Cecelia A. Monat, Nursing Outlook, July, 1967.

Reprint of the two articles available from NLN. Code no. 33-1275; $1.00.

An Approach to the Teaching of Psychiatric Nursing in Diploma and Associate Degree Programs: Workshop Report, National League for Nursing, New York, 1967. Code no. 33-1288; $1.50.

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PREFACE

Today, citizens at large as well as members of the health team have become increasingly concerned about the nation's number one health problem--mental health. An area that has been ignored for so long and even rejected by the citizenry has, at last, become a focal point for concerted interest and action. The need for this concern has been very graphically described in the 1961 report of the Joint Commission on Mental Illness and Health, Action for Mental Health, in which the following comments were made:

> We must note, for instance, the curious blindness of the public as a whole and of psychiatry itself to what in reality would be required to fulfill our well-publicized demand that millions of the mentally ill have sufficient help in overcoming the disturbances that tend to immobilize their self-respect and social usefulness.
>
> . . . we must rise above our self-preservative functions as members of different professions and different social classes and adherents of different economic philosophies and illuminate the means of working together out of mutual respect for our fellow man.
>
> . . . we each have one kind of responsibility that is common to all . . . our responsibility as citizens of a democratic nation founded out of faith in the uniqueness, integrity, and dignity of human life.[1]

Evidence of keen interest in the mental health problem was given by the late President Kennedy in his February, 1963 message to Congress. Two major pieces of legislation relating to mental illness and mental retardation were enacted by the 88th Congress, in October, 1963, as a result of the report of the Joint Commission and the report of the President's Panel on Mental Retardation.[2] They marked a major step forward in satisfying the need for a united attack on the problem. The Community Mental Health Services Legislation of 1964 and 1965 also serve as examples of legislative action designed to attack the problem. Such legislative action represents a wholly new emphasis and approach to mental health, based on the concepts of prevention and therapeutic, restorative, and rehabilitative services.

In a program of concerted interest and action on the part of all health professionals and the citizens at large, nurses must assume the initiative and responsibility for closely reviewing and assessing the contributions of nursing to the total field of mental health. Included in this evaluation would be nursing's contribution to the:

1. Promotion and maintenance of optimum mental health.
2. Prevention of mental disorder.
3. Provision for and assistance with remedial and curative care.
4. Promotion of and provision for reeduction and rehabilitation.

Thus, it may be seen quite readily that in all aspects of nursing, including activities in both intramural and extramural settings, the nurse is vitally concerned with the mental health of the patient, his family, and the community.

If we are to accept this premise, the question may well be raised, What is being done from an educational standpoint to prepare nurses to assume their responsibility in making a significant contribution to the field of mental health? All nurses are potential mental health workers. Some will be specialists in the psychiatric-mental health nursing field, but others should make a valuable contribution in whatever area of nursing they choose to function.

However, the nature and scope of the contributions that nurses will make to the field of mental health will depend upon the nature and scope of their educational program in nursing. Emphasis on the psychiatric-mental health nursing content (theory and practice) has been of fairly recent origin in the field of basic nursing education. In 1953, the NLN Board of Directors agreed that "the basic program of education for professional nursing should prepare nurses for beginning positions in the care of psychiatric patients, just as it prepares them for the care of medical-surgical, obstetric, and pediatric patients."[3] This was the first official statement by a nursing organization concerning the responsibility of preservice nursing programs to prepare beginning practitioners for psychiatric nursing.

While many schools of nursing were offering courses in psychiatric nursing at that time, there was relatively little emphasis on the preparation and recruitment of nursing students for a career in psychiatric nursing. It seemed obvious that a concerted effort needed to be made to examine nursing curriculums for the psychiatric nursing content in them, and, in particular, to examine the programs of study in the associate degree and diploma programs, since approximately 80 percent of the registered nursing students who graduated yearly were from these programs. At the present time, the graduates of diploma and associate degree programs constitute the largest source of nurse manpower.

It was also evident that changes needed to be made in nursing curriculums if students were to be prepared to function in a field where there have been significant advances in the approach to caring for people with mental health problems. The advent of community mental health centers with their day, night, evening, and weekend centers, the increasing numbers of psychiatric units in general hospitals, the emphasis on follow-up care of patients who have returned to their homes, and the increased community emphasis on the promotion of mental health and the prevention of mental illness should have broad implications for the education of nursing students.

In the context of a rapidly expanding field of mental health services and the great need for nursing services in this field, it seemed imperative that a study be made to determine existing trends in psychiatric-mental health nursing content and learning experiences in associate degree and diploma programs. It was equally important on the basis of this study to formulate suggested content, learning experiences, and teaching methods that would meet the demands of preparing a nurse to function in today's field of mental health. Thus, the project "An Approach to the Teaching of Psychiatric Nursing in Diploma and Associate Degree Programs" was conceived. The study received financial support from the National Institute of Mental Health.

This report is one of the publications resulting from the project. It is intended to serve as a tool in assisting nursing educators to clearly define expected competencies of graduates of diploma and associate degree nursing programs in psychiatric-mental health nursing. It can also be utilized by educators in all areas of clinical nursing to define the appropriate psychiatric-mental health nursing content and learning experiences that should be included in particular courses and sequence of courses in diploma and associate degree programs. In addition, the proposed method of content integration and course development should prove useful to nurse educators as they develop content and learning experiences for the entire curriculum. Nurse educators in vocational, technical, and professional nursing programs should find this report useful as they differentiate levels of practice in psychiatric-mental health nursing. Students in graduate programs that prepare nurse educators will find this report helpful in relation to curriculum development. Lastly, nursing service administrators who employ diploma and associate degree graduates in nursing can utilize this report as one means of validating their expectations of these graduates in relation to both the general practice of nursing and psychiatric nursing. Thus, this report can be utilized by all nurse educators who are concerned with curriculum development and by nursing service personnel concerned with the provision of quality nursing care to all patients.

Many people have contributed generously to the implementation of the project--and thus to the report. Consultants from the psychosocial sciences, teachers of all areas of clinical nursing in diploma and associate degree programs, psychiatric nursing educators and nursing service personnel, administrators of nursing programs, and many others have been actively involved. Without their assistance, this report could not have been written.

Nursing as a contributing member of the health team and as the largest source of health manpower is seriously concerned about its contribution to the mental health field. It is hoped that this report will be of value in assisting nurses and nursing to make a significant contribution to the mental health of all people and to the mentally ill in particular.

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INTRODUCTION

In July of 1963 the National League for Nursing was awarded a grant from the National Institute of Mental Health to support a four-year demonstration project entitled "An Approach to the Teaching of Psychiatric Nursing in Diploma and Associate Degree Programs." Funding for a fifth year for the purpose of evaluation was granted in 1967.

The project was initiated through the Mental Health and Psychiatric Nursing Advisory Service and the Department of Diploma and Associate Degree Programs at NLN Headquarters. In 1965, the Department of Associate Degree Programs was established as a separate unit. Therefore, project staff worked in conjunction with both departments as well as the Advisory Service. In 1967, when the current NLN structure was approved at the biennial convention, the Advisory Service was discontinued as a result of subsequent departmental reorganization at Headquarters. Since that time, the administration of the project has been under the Division of Research and Development with consultation from both the Department of Diploma Programs and the Department of Associate Degree Programs.

The project was proposed in response to the many requests for consultation received by the Advisory Service and the Department of Diploma and Associate Degree Programs. These requests were concerned with the need of schools of nursing for assistance with various aspects of the psychiatric nursing course in their schools and with planning for the integration of psychiatric-mental health nursing content throughout their curriculums. Another major consideration was the belief that nursing students needed to be involved in learning experiences that included the whole mental health continuum--promotion of mental health, prevention of mental disorders, and treatment and rehabilitation of the mentally ill. This type of involvement, it was felt, would lead to improved practice in all settings where individuals are in need of nursing care services.

The goal of the project is to improve the teaching of psychiatric-mental health nursing in diploma and associate degree nursing programs through the development of goals and the selection of content and learning experiences appropriate to this level of education. It is believed that improvement of the teaching process will ultimately lead to better general nursing practice in all settings as well as to increased recruitment of nurses for nursing care of the mentally ill.

The purpose of the project is to determine what goals, content, and learning experiences in psychiatric-mental health nursing should be included in diploma and associate degree education for nursing in the light of present-day trends in nursing and in psychiatric care. In order to determine the goals, content, and learning experiences, methods and materials had to be developed within the project, which would then be tested in selected associate degree programs and diploma schools of nursing.

One of the first steps taken in carrying out the project was to appoint an advisory committee to function in a consultative capacity throughout the duration of the project. Next, eight diploma schools and eight associate degree programs were chosen, according to specified criteria, to participate in the project as testing centers for the methods and materials developed within the project. The content and learning experiences in psychiatric-mental health nursing being offered by these programs at the time were assessed through a questionnaire and site visit by project staff.[1]

Major trends in both nursing education and the care of the mentally ill, underlying major assumptions, and definitions of key words and phrases (see Appendix B) needed to be identified and developed in order to give direction to the development of the methods and materials within the project.

The major trends in both nursing education and the care of the mentally ill that were identified are:

1. Two levels of nursing practice, as delineated in the ANA position paper on educational preparation for nurse practitioners.[2]
2. Integration of psychiatric-mental health nursing content throughout the curriculums of basic programs.
3. The role of the nurse in:
    a. The community mental health center.
    b. The therapeutic community as a treatment modality in psychiatric hospitals.
    c. Working with groups of patients as well as individual patients.
    d. Working with nursing and interdisciplinary teams.

These trends provided a framework for determining the major underlying assumptions, which in turn gave direction for the subsequent development of expected competencies for students and selection of appropriate content.

Although there are many ways of looking at any one issue, the particular assumptions stated were selected in order to facilitate a logical and consistent approach to the development of expected competencies for students and appropriate content. In view of generally accepted principles of education and the trends referred to above, it is felt that the following assumptions are applicable and valid for the purposes of the project:

1. Technical-level education in nursing prepares the graduate for beginning first-level practice in nursing care of patients with major health problems.
2. Psychiatric-mental health nursing content is part of all nursing content.
3. Psychiatric-mental health nursing content in the curriculum logically proceeds from simple to complex, normal to abnormal, obvious to subtle.
4. Content from the psychosocial sciences forms a base for psychiatric-mental health nursing content.
5. A course or unit in nursing care of the mentally ill is included in the curriculum and is considered and managed in the same way as other clinical courses.

On the basis of the trends, assumptions, and definitions, a general outline of beliefs relating to the teaching of psychiatric nursing in diploma and associate degree programs was developed by the staff. The purpose of this material was to outline a general approach for faculty to use when planning for the integration of psychiatric-mental health nursing content and for the course or unit in nursing care of the mentally ill in their curriculums. This material was used by the staff to give direction to the development of the methods and materials to be used within the project, i.e., the development of expected competencies and selection of content. These beliefs were reviewed by the Advisory Committee to the project and by the Steering Committee of the Council on Psychiatric and Mental Health Nursing.

Two individual consultants were utilized by the project staff at this point. One, an expert in nursing care of the mentally retarded, discussed content in this area appropriate for inclusion in technical-level nursing education. The second consultant, a director of a graduate program in psychiatric nursing, discussed organization of content.

The general outline of beliefs was sent to each director of the participating programs with a request that the total nursing faculty review and react to the statements. This was done to inform them of the direction the project was taking and to inform the project staff of any suggestions for changes and/or any disagreements with the beliefs in terms of general philosophy as well as the actuality of their program.

The next step in the development of the methods and materials was to consult with faculty representing the different clinical areas from the two types of programs.

A two-day meeting was held with five representative faculty members from diploma programs in different parts of the country. Each faculty member was responsible for teaching in one of the following areas: fundamentals of nursing, medical-surgical nursing, nursing of children, maternity nursing, or psychiatric nursing. At this meeting, the trends, assumptions, definitions, and beliefs developed and identified within the project were discussed, and suggestions solicited. The consultants' views on integration in general were discussed, and suggestions for expected competencies and critical incidents relating to psychiatric-mental health nursing were given. Broad areas of related content for integration and teaching methods were considered, as well as specific questions relating to the course in psychiatric nursing.

As in the case of the diploma program consultants, a separate two-day meeting was held with four representative faculty members from associate degree nursing programs in different parts of the country. Each faculty member was responsible for teaching in one of the following areas: fundamentals of nursing, nursing in physical illness, maternal and child health nursing, or nursing care of the mentally ill. The same topics were discussed, and suggestions were made for expected competencies and critical incidents.

Following this meeting and on the basis of suggestions made by these groups, by the participating programs, by the Advisory Committee, and by the Steering Committee, the beliefs relating to the teaching of psychiatric-mental health nursing and selected definitions were expanded into an educational and occupational orientation, or philosophy. On the basis of these orientations, expected competencies were stated for the general practice of nursing, the nurse-patient relationship, communication skills, the therapeutic environment, community aspects, and working with groups of patients, with the nursing team, and with the interdisciplinary team. Definition of terms continued to be developed as needed.

Beginning plans were made for the organization of content within a conceptual framework on the basis of a theoretical orientation.

In accordance with the project plan, two one-week meetings were held in a university setting with a group of psychiatric nurses representing different levels of nursing education and different types of settings for psychiatric care. Representatives were from graduate, baccalaureate, associate degree, and diploma education programs in psychiatric nursing and from a community mental health center and a psychiatric hospital. The purpose of these meetings was the development of methods and materials for the identification of goals and the selection of content and learning experiences in psychiatric-mental health nursing for technical-level nursing education programs.

At the first meeting, the educational, occupational, and theoretical orientations were reviewed and discussed, and suggestions made. The expected competencies and related definitions were reviewed and revised. The general plan for the organization of content was also considered. Staff were charged with developing suggestions for content, learning experiences, and evaluation methods, flowing from the expected competencies within a conceptual framework and organizational plan.

Worksheets were developed in which content in the broad areas of individual behavior, communications, and environmental influences was divided as to knowledges, skills and abilities, and attitudes and appreciations. Concurrent with the selection of content were plans for learning experiences and teaching and evaluation methods.

Further, the content, learning experiences, et cetera, were divided into that which precedes the course or unit in nursing care of the mentally ill, that which is included in the course or unit, and that which follows it.

At the second meeting of the psychiatric nursing consultants, the expected competencies and definitions were further refined. The content, learning experiences, et cetera, as organized, were discussed in detail, revised, and added to. Suggestions were made for guides for the participating schools and for implementation of the method of planning for integration in the participating programs. These suggestions grew out of the discussion of the materials and were indicated in the orientations. Suggestions for the workshop for faculty from participating programs were also made.

After refinement and revision, made on the basis of the outcomes of these meetings, all of the materials were reviewed by the Advisory Committee to the project.

The orientations, expected competencies, and content organization were further discussed on separate occasions with a consultant who is a clinical psychologist and a consultant who is a social scientist. Their suggestions were also incorporated and/or taken into consideration.

During the phase of the project when the participating programs were serving as testing centers for the methods and materials developed within the project, faculties were sent a set of questions eliciting their opinions about the expected competencies and related definitions. They had previously been sent these materials for their use as resource materials while they were developing their own expected competencies and definitions as part of their implementation of the project method of planning for the integration of psychiatric-mental health content throughout the curriculum and for the course or unit in nursing care of the mentally ill.

Out of the responses from the faculties of the participating programs, certain issues arose. These issues involved areas of question or disagreement from particular schools within the two types of programs. They could be seen as basic philosophical differences with the underlying assumptions and philosophy of the project.

There was question early in the project among some faculty in the associate degree programs as to whether associate degree nursing education should prepare their graduates for beginning first-level practice in nursing care of the mentally ill. They felt that the graduate is primarily prepared to begin functioning in a general hospital setting with medical-surgical patients, and therefore the purpose of the course or unit in nursing care of the mentally ill is for understanding behavior. At the time of the last visit, all programs agreed that they should prepare their graduates to work with the mentally ill as beginning first-level practitioners.

The largest area of disagreement among faculty in the diploma programs was whether or not the graduates of their program should be prepared as team leaders as part of beginning first-level practice. Some stated that their graduates are prepared to manage personnel and patients on the units and that team leadership is not head nursing. Following this orientation, the diploma graduate relates to the interdisciplinary team as a nursing team leader. Other diploma programs said that the diploma graduate should be prepared as a nursing team member and that the graduate of a baccalaureate program should be prepared as a team leader. Other related comments were that the diploma graduate did not need to function under continual supervision, or could not, because of the shortage of nursing personnel. Some programs felt that their graduate needed supervision, while others said she was supervised by the head nurse, not by graduates of baccalaureate programs.

Another major issue concerned the level of preparation and practice of the graduate of a diploma program. Some faculties considered their program to be characteristic of professional education while others stated their program was technical in nature. One program said that the diploma graduate is semiprofessional, while two others said that she is a professional nurse--that there is no difference between the baccalaureate and diploma graduate. Faculty in some programs stated that two levels of practice will develop in the future.

One program said that the project's expected competencies fit the baccalaureate graduate as well, while another answered that any aide could do these things. There was also dispute within the diploma programs as to whether or not their graduates were prepared to do other than in-patient care. Some said that with the current trend toward health and medical care outside the hospital, diploma graduates must be prepared to function in extended care programs. Some of the diploma programs said that the expectations of the employing agencies determined their educational program.

Some of both types of programs stated that it was difficult to use the course in general psychology and the course in general sociology as a foundation for psychiatric-mental health nursing content because of their curriculum structure and the difficulties in keeping up with the content changes in these two courses. The alternative is to use these courses as supportive or as part of a liberal-cultural background. However, they felt that these courses should be foundational.

It was difficult to provide laboratory experience in the nurse-patient relationship, in working with groups of patients, and in participating in interdisciplinary team discussions as a nursing team member in the general and psychiatric hospital because of agency restrictions, i.e., lack of community agencies, lack of facilities in the agency, lack of cooperation of nursing service personnel and other health team members, and lack of preparation of nursing service personnel and other health team members. One school from each type of program questioned whether mental health and mental illness were on a continuum or were separate entities.

Two questions that arose were: (1) whether or not diploma or associate degree education should prepare the graduate to work with groups of mentally ill patients, as in discussion or recreational groups, and (2) whether content and learning experiences related to group functioning and the therapeutic environment should be integrated throughout the curriculum or be within the province of psychiatric nursing only.

The next phase of the project was concerned with the utilization by the participating programs of the project method of planning for integration of psychiatric-mental health nursing content within the curriculum and for the course or unit in psychiatric nursing or nursing care of the mentally ill.[3]

As a first step in this phase of the project, a workshop[4] was planned for representatives of the participating programs. The purpose of the workship was to provide the faculty representatives with direction in using the project method of planning for the integration of psychiatric-mental health nursing content throughout their curriculums. Prior to the workshop, one diploma school asked to be dropped from the project because of faculty turnover.

The workshop was held for five consecutive days. Each project school was represented by two faculty members. Generally, the associate degree programs were represented by the psychiatric nursing instructor and the instructor who works most closely with her; the diploma school participants were most often the psychiatric nursing instructor and the curriculum coordinator.

Representatives were, on return to their programs, to assist their faculty in using the project method in planning for integration and for the course. Resource materials in the form of definitions, suggested expected competencies, worksheets, and bibliographies were provided.

Tentative plans were made by the representatives at the workshop regarding what their faculties might do in utilizing the project method and materials in their respective schools. These plans were, of necessity, subject to revision by and approval of the entire faculty and the director upon the representatives' return to their schools.

After the workshop, project staff made site visits to the participating programs as consultants to assist faculties in their implementation. At the end of the year, faculties were asked to submit to the project staff their plans on the worksheets provided them. The following year, staff again made visits to the participating programs for the purpose of:

1. Ascertaining the progress faculties had made in order to further assist them in their implementation.
2. Determining each faculty's evaluation of the method of planning.
3. Eliciting a description of the uses made of the project materials by faculties.
4. Evaluating the project.
5. Discussing the issues that arose as a result of their responses to the questions on the definitions and competencies.
6. Requesting suggestions for the content of publications that were to be an outcome of the project.

In general, the majority of the participating programs stated that they had gained what they had hoped from their participation in the project. Their participation definitely helped them in their problems of integrating psychiatric-mental health nursing content throughout their curriculums. Some of the programs said that they had been able to overcome some of their problems in the course or unit in nursing care of the mentally ill. Others had not yet had an opportunity to implement their plans for the course or unit. Two programs had structural problems with the course or unit that have not been solved. One program did not solve its related problems through participation in the project.

Throughout the course of the project, progress reports were made by project staff to both the associate degree and the diploma programs' Councils of Member Agencies and their respective Steering Committees, to some local and state Leagues for Nursing, and to several workshop groups.

It was part of the project plan for guidelines and resource materials to be published for use in the development of course offerings and in the selection of educational resources in psychiatric-mental health nursing in diploma and associate degree nursing education programs. The definitions and expected competencies developed within the project are included as part of this material. This publication, then, includes suggestions as to what faculty should do to achieve effective content integration and course development in psychiatric-mental health nursing and ideas and materials that have been developed within the project.

A final report on the project process, method, and results is in preparation.

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PHILOSOPHY

As is the case when planning for any area of content integration and course development, the process of planning for integration of psychiatric-mental health nursing content throughout the curriculum and for the course in psychiatric nursing begins with the identification by the entire faculty, including the director, of the need for engaging in this activity. The importance of this as a first step cannot be overemphasized. If the result of faculty work in any area of curriculum development is to be truly effective, the felt need for this activity cannot be imposed by sources outside the faculty group, but must emanate from within. Of equal importance is the faculty's having the support of the director in their endeavor.

In order for all faculty members to have a clear understanding of what they hope to achieve as a result of integrating psychiatric-mental health nursing content throughout the curriculum, they must state their objectives.

For the purposes of the study, the broad objectives of integration are twofold:

1. To enable students to give quality nursing care to all patients.
2. To provide a base of content and experience that deals with normal behavior and can be built upon in the course in psychiatric nursing and followed up in succeeding courses.

With their goals clearly in mind, the faculty then develops and/or reviews the philosophy of the program. The philosophy is a reflection of their beliefs about the practice of nursing and nursing education. The program philosophy should be consistent with the over-all philosophy of the institution in which the program exists.

A philosophy is much more than a mere collection of words. It is the set of beliefs upon which the structure and conduct of the program is built. However, since it must be expressed through the use of words, it is imperative that all faculty members, including the director, be involved in its development and have a common understanding of and agree upon that which they are stating.

Specifically, the faculty identifies, discusses, and agrees upon a philosophy of nursing in general, psychiatric nursing, and nursing education. In this instance, the faculty needs to determine what they believe about education for beginning first-level nursing practice on a technical level, including nursing care of the mentally ill.

The following statements reflect the beliefs developed within the study.

Nursing practice is concerned with the health and welfare of human beings. Its distinctive feature is the responsibility of doing for, or together with, a person, in whole or in part, that which he and/or his family ordinarily would do but are unable to do for a time or at all times.[1]

Direction for implementation of this practice (nursing functions) is derived from consideration of the nature of man in health and in illness:

1. In relation to himself.
2. In relation to other men as individuals and in groups.
3. In relation to the environmental elements with which man lives.

Examples of knowledges about the nature of man that have particular relevance for the psychosocial aspects of nursing practice are:

1. Survival of the human organism depends on adaptations to internal and external stress.
2. There is an inextricable relationship among the physical, mental, emotional, and spiritual aspects of man.
3. All human needs are interrelated; a disturbance in one area of function will cause reciprocal reactions in other areas of function.
4. Man constantly strives for psychophysiological homeostasis (equilibrium).
5. In order to achieve and maintain psychological equilibrium, man must have satisfying relationships with other human beings, both individually and in groups.
6. Man is an indivisible phenomenon in constant interaction with all parts of the environment.

Keeping the preceding in mind, the following can be said: Nursing practice is directed toward identifying and meeting in varying degrees the physical, social, emotional, and spiritual needs of the individual to the end that he is enabled to achieve or resume his position in society, to function within the limitations imposed by his illness, or to conclude his life cycle as comfortably as possible.

There are seven areas of nursing function, the first six of which are independent:[2]

1. The supervision of a patient involving the whole management of [nursing] care, requiring the application of principles based upon the biologic, the physical, and the social sciences.
2. The observation of symptoms and reactions, including symptomatology of physical and mental conditions and needs, requiring evaluation or application of principles based upon the biologic, the physical, and the social sciences.
3. The accurate recording and reporting of facts, including evaluation of the whole care of the patient.
4. The supervision of [nursing personnel and coordination of] others, except physicians, contributing to the care of the patient.
5. The application and execution of nursing procedures and techniques.
6. The direction and the education to secure physical and mental care.

The one dependent area of nursing function is:[3]

7. The application and the execution of legal orders of physicians concerning treatments and medications, with an understanding of cause and effect thereof.

In addition to the broad legal nursing functions outlined above, nursing also includes the following more specific functions:[4]

1. Ministering to the basic human needs.
2. Teaching self-care or counseling on health.
3. Participation in the patient's restorative activities in modification of daily living.
4. Planning with the patient for self-care, which is an outgrowth of managing the care for him--determining and timing the course of action and controlling the manner of its performance.
5. Communicating and interacting with the patient throughout all of these--to give the patient opportunities to develop a sense of trust, a feeling of significance and ultimately of self-realization.

The nurse is prepared to execute the foregoing functions as a result of the transmission of knowledges and the development of skills. This preparation takes place in an educational institution, and therefore, the following general principles of education must be adhered to.

1. The faculty in an educational institution has the responsibility of planning, implementing, and evaluating the educational program.
2. The planning, implementation, and evaluation of the educational program is a mutual endeavor of the total faculty.
3. The educational program has both a philosophy and a set of program objectives, clearly stated.
4. The philosophy and objectives of the program are consistent with the philosophy and objectives of the institution.
5. The central focus of an effective program is the education of its students.
6. Effective education results in observable changes in the learner's behavior.
7. One of the desired outcomes of the educational program is the development of the student's ability to think logically and to use the scientific method in dealing with problems.
8. Another desired outcome of the educational program is to prepare the student to assume his place as a contributing member of society as a whole and to continue his development as an individual and a citizen.
9. The curriculum operates as a whole, and changes or modifications will influence the total program.
10. The objectives of individual courses are consistent with the philosophy and objectives of the total program.
11. The continuity and sequence of courses are so structured that foundational subjects provide the basis for other courses, so that at the completion of the coursework, the objectives of the program will have been fulfilled.
12. Each course is conducted within an agreed-upon broad framework that operates throughout the entire program. This framework is consistent with the philosophy and objectives of the program, with deviations occurring only as they are determined by individual course objectives and content.
13. Significant threads of content that are integrated throughout a program are identified. Content that precedes and that which is to follow a course is one determinant of the objectives of the course.
14. Course sequence, content, and learning experiences proceed from simple to complex, normal to abnormal, concrete to abstract, and obvious to subtle. In this way, the learner can acquire a meaningful depth and breadth of knowledges and skills resulting in abilities.
15. New courses, content, and learning experiences are introduced to the learner gradually through building on previously acquired knowledges, skills, and abilities.
16. Objectives are explicit statements of the way in which it is expected students will think, act, or believe as a result of participating in the planned activities. It is important that they be:[5]
    a. Stated in terms of changes in knowledges, skills, abilities, attitudes, and appreciations.
    b. Clearly expressed with respect to the competencies expected of the graduates of the program when they are ready for their first position.
    c. Specific descriptions of what the learner will be doing when demonstrating achievement thereof.

17. Teaching methods to be used in the course are indicated by content and objectives.
18. When objectives include the development of skills, this is best accomplished in a laboratory. Laboratory facilities are selected on the basis of the objectives.
19. Laboratory experiences are educationally oriented.
20. Facilitation of the educational process may require use of and coordination with other facilities and services available within the institution and the community.
21. Contracts and agreements between the educational institution and community facilities provide opportunity for meeting the educational objectives of the experience.
22. Course outlines show the relationship among experiences in the classroom, in the laboratory, and in conference. They are concurrent in time and content.
23. The purpose of evaluation is to determine to what extent each student has acquired the knowledges, skills, attitudes, and appreciations identified in the objectives of the curriculum and in the individual courses.
24. Evaluation is in terms of the degree of competency that the student demonstrates as a result of the learning experiences.
25. To provide a valid basis for evaluation, the objectives must be defined in behavioral terms and the learning experiences must be such as to permit expression in behavioral outcomes.

Nursing is one of the health occupations, which provides a service to the individual, the family, and the community in health and in illness. The occupation of nursing includes several levels of practitioners: professional, technical, and vocational.[6] In addition, there is a group of semiskilled workers who assist the nurse in her practice.

The occupational level of nursing with which we are concerned is the technical level. The following definition of a technical occupation in general provides a frame of reference for the development of beliefs about the nature and function of a nurse at this level.

A technical occupation is said to be "a vocation requiring skillful application of a high degree of specialized knowledge together with a broad understanding of operational procedures; involving the frequent application of personal judgment; usually dealing with a variety of situations; and often requiring the supervision of others. It offers the opportunity for the worker to develop an ever increasing personal control over the application of his knowledge to his work and usually requires fewer motor skills than a trade or a skilled occupation and less generalized knowledge than a profession."[7]

Therefore, education for technical-level occupations has the following characteristics:

1. An educational program that prepares for technical-level occupations makes use of general principles of education in its implementation.
2. The biological, physical, and behavioral sciences serve as underpinnings for theory and subsequent practice.
3. An educational program that prepares for occupations responds to the needs of the community, influences and is influenced by the community, and utilizes the facilities of the community.
4. Effective educational programs that prepare for occupations result in changes in student behavior; i.e., in knowledges, skills, abilities, attitudes, and appreciations.
5. Behavioral changes occurring as a result of the educational program permeate

the student's entire life and help to prepare him to function effectively not only as an occupational practitioner but also as a responsible citizen.

6. Educational programs for technical-level occupations are terminal in nature--*i.e.*, complete in themselves--and prepare graduates for immediate employment.
7. An educational program for an occupation prepares its graduates for beginning first-level positions.
8. Effective functioning in beginning positions requires orientation, supervision, and inservice education.
9. Effective functioning in first-level positions requires continuing supervision and inservice education.

When the definition of a technical occupation cited above is applied to the practice of nursing, we can say that the nurse at this level is a *beginning first-level practitioner of nursing*. For the purposes of this study, the term a *first-level practitioner* designates a nurse who administers direct nursing care; *i.e.*, performs intermediate nursing functions[8] requiring skill and some judgment, in the presence or at the bedside of the patient who is under the care of a physician.[9] She is a contributing *member* of the nursing team and works under the supervision of a nurse with broad professional preparation.[10] She assumes some responsibility for the direction and supervision of those ancillary personnel who are members of the same team.

A beginning first-level practitioner is a technical nurse who has graduated from a state-approved diploma school or associate degree program of nursing, is eligible for licensure or is currently licensed in the state in which she practices, and has had less than one year's work experience in nursing after graduation.

Education for technical-level nursing practice has the following characteristics:

1. Educational programs that prepare for technical-level nursing practice adhere to general principles of education and characteristics of occupational education.
2. Technical-level nursing education prepares the graduate to assume beginning first-level positions.
3. Beginning first-level positions require orientation, supervision, and inservice education.
4. The beginning first-level practitioner is prepared as a bedside (patient-side) nurse and functions as a team member.
5. The beginning first-level practitioner is educated to give nursing care to patients of all ages with major health problems.
6. Nursing care at the technical level is concerned with the needs of the "total patient," and therefore includes emotional-social aspects of nursing care.
7. All clinical nursing courses include the emotional-social aspects of patient care as an *integral* part of the content.
8. Content in the behavioral sciences is a theoretical underpinning for content in emotional-social aspects of nursing care.
9. Although the focus of nursing care may vary, depending upon the health problem the patient is experiencing, the knowledges, skills, abilities, attitudes, and appreciations that are acquired and/or developed in technical-level nursing programs are utilized in the nursing care of all patients.
10. Knowledges and skills in nursing are best acquired when content and learning experiences proceed from simple to complex, normal to abnormal, concrete to abstract, and obvious to subtle.

11. In order to give nursing care to the ill person and to promote health, the nurse needs a knowledge and an understanding of normal physical and mental processes.
12. In order for the student to achieve depth of learning, continuity and sequence of courses in the nursing curriculum are structured so that foundational subjects provide the basis for other courses.
13. Current practices and trends in health care of patients of all ages with major health problems influence education for technical-level nursing.
14. The faculty is responsible for identifying and assessing resources for student learning experiences.
15. Since health care is moving toward a community approach, all community facilities that have as their focus maintenance of health, prevention of illness, and rehabilitation of those who are ill are considered in planning for student learning experiences.
16. It is the responsibility of the clinical agency to make available laboratory and other facilities that are conducive to effective learning.
17. The nursing service units in which students have their clinical laboratory experience must be so organized as to create an environment in which effective learning can take place and in which quality nursing care administered by all categories of nursing service personnel can be observed.
18. The personnel in the nursing service department of an agency must understand the philosophy and objectives of the educational program, and the faculty, in turn, needs to understand the philosophy and objectives of the nursing service department.

Since technical-level nursing practice includes the care of all patients with major health problems, and since mental illness is, without doubt, a leading major health problem, the faculty must reach agreement upon the nature of mental health and mental illness, psychiatric nursing in general, psychiatric nursing at the technical level, and education for psychiatric nursing at this level.

It is assumed that the faculty understands that the knowledges, skills, abilities, attitudes, and appreciations required to give beginning first-level nursing care to the mentally ill patient can be acquired by the student within the scope of technical-level nursing education.

For the purpose of this study, mental health is said to be a state of being resulting from a personality that is organized in a manner that:

1. Is acceptable to the individual.
2. Results in optimum growth and development, or self-actualization.
3. Enables the person to function autonomously.
4. Enables the person to perceive reality with minimal distortion.
5. Enables the person to achieve mastery over his environment.
6. Enables the person to have positive affective relationships.

This personality organization is manifested by, and inferred from, patterns of behavior. Mental health has no absolute inherent value. Therefore, when concerned with evaluating the degree of mental health achieved by a person, consideration must be given to standards set by the culture in which he lives and his total personality structure. The above criteria are interdependent and are guides rather than rules for the assessment of the degree of mental health manifested by an individual.[11]

If mental health and mental illness are seen as extremes of a continuum, and if the behavioral manifestations of the mentally ill are believed to be complex exaggerations of normal behavior, then mental illness[12] can be defined as a state of being of a living human organism manifested by, and inferred from, his patterns of behavior. Behavior considered to be indicative of mental illness is determined in part by the individual's total personality organization and the values held by the culture to which the individual belongs. Therefore, "mental illness" is not an absolute concept, but a state that varies from individual to individual and from culture to culture. It is also not absolute in the sense that no person is totally mentally ill, but rather manifests behavior indicative of varying degrees of health and illness.

Generally, then, mental illness is a behavioral manifestation of the degree to which the individual's reaction to himself and his interaction with others and the environment are inadequate and/or inappropriate in light of his own total personality organization and the culture to which he belongs.

Specifically, in the United States mental illness has been classified by the Committee on Nomenclature and Statistics of the American Psychiatric Association for the use of physicians in whose province lies the responsibility for diagnosing illness.

The field of nursing that provides nursing care to patients where the major therapeutic goal is the promotion of mental health, the prevention and detection of mental illness, and the treatment and rehabilitation of patients with psychiatric disorders is labeled psychiatric nursing.

As with all areas of nursing practice, the functions of the psychiatric nurse are determined to some extent by the current practices and trends in the health care of all patients. In providing nursing care to the mentally ill, the function of the nurse is not different in nature from nursing in other clinical fields, but it does differ in its primary focus on interpersonal, one-to-one, and group relationships.[13]

More specific functions of the psychiatric nurse include:[14]

1. Creating a therapeutic environment--acceptance, understanding, and provision of opportunities for the patient's emotional growth.
2. Studying the ward social structure in order to promote healthy socialization.
3. Establishing relationships with individual patients.
4. Establishing relationships with groups of patients.
   a. Structured or formal groups (patient government meetings, remotivation, activity groups, et cetera).
   b. Unstructured or informal groups (spontaneous discussions, et cetera).
5. Intervening in crisis situations.

The general goal of psychiatric nursing is to help patients to accept themselves and to improve their relationships with other people.[15]

The field of psychiatric nursing includes several levels of practitioners--the professional psychiatric nurse (clinical specialist), the professional nurse, the technical nurse, and the vocational nurse--all of whom work with patients who are mentally ill. In addition, there is a group of semiskilled workers who assist the nurse in her practice.[16] Hereafter, beginning first-level practice in psychiatric nursing will be referred to as nursing care of the mentally ill in order to differentiate technical-level practice. The nurse functioning at this level will be referred to as a beginning first-level practitioner in nursing care of the mentally ill.

For the purposes of this study, the term first-level practitioner in nursing care of the mentally ill designates a nurse who administers direct supportive nursing care to the mentally ill patient on a one-to-one or small-group basis. Direct supportive nursing care is rendered in the daily living situation in which the nurse and the patient find themselves and is consistent with the over-all treatment goal for the patient determined by the interdisciplinary team. The nurse focuses on strengthening the patient's areas of health and deals only with those thoughts and feelings that the patient brings up and with his behavior. Her nursing care is purposeful and planned, and although it may take many forms, it is based on her knowledges, skills, abilities, attitudes, and appreciations regarding the behavioral manifestations of the major forms of mental illness. Her primary therapeutic tool in her interactions with patients is "use of self."

In all her activities, the first-level practitioner in nursing care of the mentally ill functions under the supervision of a nurse with broad professional preparation in nursing or a professional psychiatric nurse. She is a contributing member of the nursing team and also functions as such on the interdisciplinary team as it establishes and implements total treatment plans for the patient.

A beginning first-level practitioner in nursing care of the mentally ill is a technical nurse who has graduated from a state-approved diploma school or associate degree program of nursing, is eligible for licensure or is currently licensed in the state in which she practices, and has had less than one year's work experience after graduation in nursing care of the mentally ill.

Education for beginning first-level practice in nursing care of the mentally ill, then, has the following characteristics.

1. Education for beginning first-level practice in nursing care of the mentally ill adheres to the same educational principles followed in the total nursing curriculum and is an integral part of the curriculum.
2. It is the responsibility of the faculty to plan, implement, and evaluate the course or unit in nursing care of the mentally ill.
3. The focus of the course or unit devoted to nursing care of the mentally ill patient is on the acquisition and/or development of those knowledges, skills, abilities, attitudes, and appreciations necessary to:
   a. Give beginning first-level nursing care to mentally ill patients, individually and in small groups.
   b. Function as a nursing team member.
4. The conduct of the course or unit in nursing care of the mentally ill is consistent with that of the rest of the courses in the nursing curriculum.
5. Content in the behavioral sciences is a theoretical underpinning for specific content and learning experiences in the course or unit in nursing care of the mentally ill.
6. Knowledges, skills, abilities, attitudes, and appreciations regarding behavior are broadened and deepened, rather than introduced, in the course or unit in nursing care of the mentally ill.
7. Since behavioral manifestations of mental illness are complex exaggerations of normal behavior, knowledge of normal physical and mental processes provides a basis for understanding the behavior of mentally ill patients.
8. Knowledge and understanding of the behavior of the mentally ill patient provides the basis for planning individualized nursing care for these patients, utilizing the problem-solving approach.
9. Current practices and trends in the health care of the mentally ill patient influence education for technical-level nursing care of the mentally ill. At the present time, practices and trends in the health care of the mentally ill include a community approach (including general hospital treatment of the mentally ill, follow-up care and rehabilitation of persons who have been mentally ill, and

mental hygiene clinics for prevention of mental illness), an interdisciplinary approach, and an individual and small-group approach.

10. The faculty is responsible for identifying and assessing resources for student learning experiences.
11. All community facilities concerned with health care of the mentally ill are considered in planning student learning experiences.

On the basis of all that has been said in this section, the following five major assumptions are made. These assumptions provide one base for the content development that follows this section.

1. Technical-level education in nursing prepares the graduate for beginning first-level practice in nursing care of patients with major health problems.
2. Psychiatric-mental health nursing content is part of all nursing content.
3. Psychiatric-mental health nursing content in the curriculum logically proceeds from the simple to complex, normal to abnormal, obvious to subtle.
4. Content from the psychosocial sciences forms a base for psychiatric-mental health nursing content.
5. A course or unit in nursing care of the mentally ill is included in the curriculum and is considered and managed in the same way as other clinical courses.

The faculty is now ready to begin planning competencies for the integration of psychiatric-mental health nursing content and for the course or unit in nursing care of the mentally ill.

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TERMINAL EXPECTED COMPETENCIES AND LEVEL OR COURSE COMPETENCIES

After the faculty has looked at (1) the philosophy and objectives of the educational institution of which they are a part, (2) their own over-all philosophy of nursing in relation to man in health and in illness, (3) their own philosophy of education in general and nursing education in particular, (4) their philosophy of technical-level nursing and education for technical-level nursing, and (5) the way they view mental health and illness, their views of psychiatric nursing, psychiatric nursing at the technical level (nursing care of the mentally ill), and education for nursing care of the mentally ill, they are then ready to consider their curriculum objectives--in this case, what they are trying to accomplish through integration of psychiatric-mental health nursing content throughout the curriculum. The goals of content integration in a curriculum should be clearly identified and agreed upon by the faculty, including the director of the program.

In order to engage in the process of integrating psychiatric-mental health nursing content, the faculty will have to agree that knowledges and skills required for psychiatric-mental health nursing are part of the knowledges and skills required for all nursing care. They will also have to view the course or unit in nursing care of the mentally ill, not as a specialty, but as part of the general nursing curriculum, and see to it that the structure, goals, and methods of the course are consistent with those of the rest of the nursing courses in the curriculum.

Throughout the process of planning, implementing, and evaluating the integration of content, it is essential that the faculty agree on the meaning of the terms that they are using. Following are definitions of pertinent terms adopted for use within the project.

Integration: The process of forming new, larger, and more comprehensive whole responses by which differentiated objects and activities are apprehended. It is the combining of details which emerge from large wholes and ultimately acquire such a degree of individuality and specificity that they are united with other particulars and are reorganized into a coherent pattern."[1] For the purposes of this study, the learning experiences provided by the instructor will be such that content from psychology and sociology as well as psychiatric-mental health nursing content will be interwoven throughout the clinical courses in the nursing curriculum. While learning experiences that facilitate integration of content are provided by the instructor, the process of integration takes place within the student.

Psychiatric-Mental Health Nursing Content: For the purposes of this study, psychiatric-mental health nursing content is considered to be the knowledges that are related to the understanding of individual and group behavior. These knowledges are based on the psychosocial sciences, the biophysical sciences, and psychiatry. When applied in the practice of nursing, these knowledges are manifested in the ability to engage in nurse-patient interactions, nursing interventions, and the nurse-patient relationships, on both an individual and small-group basis. Inextricably involved in all of these abilities are communication and/or interviewing skills, skills in environmental modification, and appropriate attitudes in giving nursing care to all patients; i.e., both the physically ill and the mentally ill. Therefore, psychiatric-mental health nursing content is part of all nursing content.

The next step is for the faculty to write their curriculum objectives in behavioral terms as terminal expected competencies for general nursing practice. The competencies are the minimal acceptable level of achievement expected of the student immediately prior to completion of the program preparing her as a beginning first-level practitioner in nursing. The writing of the behaviors follows the general educational principles listed on pages 10-11 of the preceding section. For example:

> Objectives are explicit statements of the way in which it is expected students will think, act, or believe as a result of participating in the planned activities. It is important that they be:
> a. Stated in terms of changes in knowledges, skills, abilities, attitudes, and appreciations.
> b. Clearly expressed with respect to the competencies expected of the graduates of the program when they are ready for their first position.
> c. Specific descriptions of what the learner will be doing when demonstrating achievement thereof.

For the purposes of this study, terminal expected competency is defined as the description of the desired outcome or outcomes of a program of studies, a course, or any given learning experience. It is stated in behavioral terms describing the expected performance of the student that has been established as the minimal acceptable level of achievement at the end of a planned unit of instruction and indicating that the learner has achieved the objective or objectives; i.e., there has been a behavioral change in the student. It is derived from and consistent with the philosophy of the program.[2]

Since planning for integration is part of total curriculum planning, terminal expected competencies related to psychiatric-mental health nursing should be an integral part of the terminal expected competencies in general. Following is an example of terminal expected competencies related to the general practice of nursing which was developed as a part of the project. Psychiatric-mental health aspects of nursing care are implied or indicated.

Terminal Expected Competencies Related to the General Practice of Nursing

I. The student has an appreciation of herself both as a person with varying physical, psychological, and developmental needs and as a practitioner with responsibilities, potentialities, and limitations.

II. The student gives safe, effective nursing care to one or a group of patients with major health problems, under the supervision of a nurse with broad professional preparation.

   A. Develops an individualized nursing care plan based on patient needs and nursing problems, using the problem-solving approach.
      1. Identifies patient needs and nursing problems.
      2. Hypothesizes about the reasons for patient needs and nursing problems.
      3. Identifies appropriate nursing care and states the reasons for its appropriateness; e.g., the nurse-patient relationship.

    4. Cooperates with and contributes to the nursing team as a team member in planning for nursing care.
    5. Cooperates with members of other disciplines and contributes to the planning for total patient care as she plans for nursing care.
    6. Evaluates her own knowledges, skills, abilities, attitudes, and appreciations as they may influence her nursing care.

  B. Implements her plan for nursing care.
    1. Adjusts her plan on a priority basis, taking into consideration both direct and indirect influences on patient needs and nursing problems.
    2. Recognizes her limitations and seeks appropriate assistance.
    3. Cooperates in coordinating nursing care of assigned patients with the care given by other health workers.

  C. Evaluates her plan for nursing care.
    1. Identifies changes in patient needs and nursing problems.
    2. Determines the effectiveness of nursing care in terms of the nursing care plan and the total treatment plan.
    3. Validates her findings with other health workers.

  D. Revises her plan for nursing care on the basis of the evaluation.
    1. Supplements knowledges and develops skills as needed.
    2. Seeks appropriate assistance.

III. The student relays pertinent information accurately and appropriately.

  A. Differentiates between events and inferences.
  B. Describes patient needs and nursing care given.
  C. Reports crucial information immediately.
  D. Writes a pertinent account of her observations and her nursing care.

The next step is to write the terminal expected competencies related to psychiatric-mental health nursing that grow out of the over-all competencies related to the general practice of nursing. The expected competencies related to this area that were identified in the project as examples fall into three categories:

1. Those related to the nurse-patient relationship.
2. Those related to working with groups, including groups of patients, the nursing team, and the interdisciplinary team.
3. Those related to the therapeutic environment.

The following competencies are examples of minimal levels of student achievement immediately prior to graduation from a technical-level program in nursing education. They were evolved from the general scheme outlined on pages 8 and 9 that grew out of consideration of the nature of man in health and illness:

1. In relation to himself.
2. In relation to other men as individuals and in groups.
3. In relation to the environmental elements with which man lives.

Obviously, there is considerable overlapping of the categories of competencies within the conceptual framework.

Terminal Expected Competencies Related to the Nurse-Patient Relationship

I. The student has an appreciation of herself both as a person with varying physical, psychological, and developmental needs and as a practitioner with responsibilites, potentialities, and limitations.

II. The student engages in a supportive relationship, as the need dictates, with a selected patient under the supervision of a nurse with broad professional preparation.

  *A. Plans for the supportive relationship based on patient needs and nursing problems, using the problem-solving approach.

    1. Initiates contact with the patient.
    2. Assesses the patient's present and potential capabilities and goals, taking into consideration his limitations, both physical and emotional.
    3. Avoids labeling the patient.
    4. Writes a plan for the supportive relationship that is a part of the over-all nursing care plan.
    5. Plans the supportive relationship so that it is part of the total treatment plan for the patient.

  B. Implements her plan for the supportive relationship.

    1. Establishes the supportive relationship.
      a. Orients the patient to the functions and purposes of the relationship, setting limits on the relationship.
      b. Begins consideration of plans with the patient for conclusion of the relationship.
      c. Identifies roles she assumes in the relationship.
    2. Continues the supportive relationship.
      a. Recognizes when the relationship is in the continuing phase.
      b. Recognizes her limitations and seeks appropriate assistance.
      c. Recognizes that her feelings about the patient influence her behavior toward him, which in turn influences his behavior.
      d. Identifies and accepts as not personally significant the patient's positive and negative verbalizations and behaviors.
      e. Exhibits positive attitudes toward the patient; _e.g._, she is:
        (1) Nonpunitive.
        (2) Nonjudgmental.
        (3) Accepting.
        (4) Permissive.
        (5) Empathic.
      f. Promotes the relationship through nursing actions based on the patient's needs; _e.g._,
        (1) Carries out individualized safety measures.
        (2) Sets realistic limits for the patient.
        (3) Stays with or leaves the patient when this action would benefit him.

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*All that follows is an artificial separation of a process that is closely interwoven and overlapping but has been outlined to make student evaluation more feasible.

        (4) Is consistent in her behavior and attitudes.
        (5) Utilizes communication skills knowledgeably.
            (a) Is aware of the relationship between her communication and the response of others.
            (b) Is aware of the effect of her anxiety on her ability to communicate purposefully.
            (c) Attends to the communication of others.
            (d) Observes nonverbal communications.
            (e) Recognizes prominent themes in the communication of others.
            (f) Tolerates silence.
            (g) Keeps open the flow of effective verbal communication.
            (h) Validates the communications of others with them.
            (i) Is purposeful in her communication.
            (j) Is selective in her verbal response.
            (k) Limits her communication to discussion of the current situation.
            (l) Respects the principles of confidentiality.
    g. Recognizes the implications of signs of change in patient behavior; e.g.:
        (1) Level of anxiety.
        (2) Level of depression.
        (3) Level of withdrawal.
        (4) Level of hostility.
    h. Accepts the patient's progressive independence.
    i. Continually revises her plan for the relationship as needed (see item C below).
    j. Discusses those feelings about the patient that affect her nursing care with a nurse with broad professional preparation.
3. Concludes the supportive relationship.
    a. Follows through on plans previously made with the patient for conclusion of the relationship.
    b. Identifies and accepts her feelings of separation anxiety.
    c. Identifies and accepts the patient's feelings of separation anxiety as evidenced by his behavior.

C. Evaluates her plan for the supportive relationship.

1. Identifies changes in patient needs and nursing problems on the basis of changes in the patient's behavior.
2. Determines the effectiveness of the relationship in terms of the goals of the relationship.
3. Accepts the patient's present and potential capabilities and goals, taking into consideration his limitations, both physical and emotional.
4. Recognizes and accepts her limitations in the relationship.

D. Revises her plan for the relationship on the basis of the evaluation.

1. Supplements knowledges and skills as needed.
2. Seeks appropriate assistance.

Terminal Expected Competencies Related to Working With Groups

I. The student functions in group situations with patients, with the nursing team as a team member and also functions as such on the interdisciplinary team.

A. Is aware of her strengths and limitations and seeks appropriate assistance.
B. Is aware of the possible effects of her own behavior on others in the group.
C. Identifies her role as a nurse in the group.
D. Maintains and interprets her role in the group.
E. Assumes other appropriate group roles in the group.
F. Contributes to the group by supplying information from her frame of reference.
G. Considers the group needs in planning, initiating, and following through on group discussions and activities.
H. Utilizes unstructured group situations to engage the group in activity or discussion toward planned ends.
I. Cooperates with and contributes to the total functioning of the group.
J. Communicates purposefully in her interactions in the group.
K. Appreciates the possible effects of each group member on others in the group.
L. Identifies constructive and destructive group interaction.
M. Supports constructive interaction among group members.
N. Intervenes in destructive group interaction directly or by seeking appropriate assistance.
O. Discusses her feelings about the group with the group and/or with a nurse with broad professional preparation.

Terminal Expected Competencies Related to the Therapeutic Environment

I. The student contributes to the establishment and maintenance of a therapeutic environment.

A. Considers in her nursing care plan the effect of the immediate environment on the patient.
B. Is aware that health workers have an influence on the environment.
C. Identifies disruptive and therapeutic factors in the environment.
D. Initiates modifications in the immediate environment of assigned patients when needed and when possible.
E. Carries out safety measures.

Terminal expected competencies related to the nurse-patient relationship have been considered from the standpoint of a one-to-one relationship between any patient in any clinical setting and a nursing student functioning at the beginning technical level. Although learning experiences concerned with the nurse-patient relationship can be provided in any clinical setting, they most frequently take place in depth in the course or unit in nursing care of the mentally ill. It should be noted that the nurse-patient relationship is part of the over-all nursing care plan that is planned with the nursing team and is in conjunction with the over-all interdisciplinary plan for care of the patient. The technical-level nurse is always under the supervision of a nurse with broad professional preparation.

The terminal expected competencies related to working with groups include those that are needed by the nurse to (1) work with patient groups in group discussions or activities, (2) work with the nursing team as a team member, and (3) participate on the interdisciplinary team within the limits of her preparation.

Terminal expected competencies concerned with the therapeutic environment are part of the over-all nursing care plan. The nurse at the technical level is not prepared to function in a therapeutic community without additional preparation.

For diploma programs or those programs that have rotation plans, the next step is to write expected competencies for each level. The last-level competencies would be the terminal competencies. Earlier-level competencies are a further breakdown of the terminal competencies and show progression by depth and sequence.

After the writing of the expected competencies for each level, course competencies are written and included as an integral part of the other competencies for each nursing course.

The faculty in an associate degree program would break down the terminal expected competencies into the course, or semester, competencies. The course competencies show progression by depth and sequence and are planned as an integral part of the total course competencies.

Instructors representing all clinical areas in the curriculum jointly plan for integration of psychiatric-mental health nursing content by developing terminal (level in diploma programs) and course competencies. In this manner, instructors know each others' course competencies, so that duplication and overlapping can be avoided and progression in depth and sequence can be attained.

Another way of expressing the results of the process described above is that the statement of expected competencies for each clinical course includes or indicates psychiatric-mental health nursing content.

In developing competencies for the course or unit in nursing care of the mentally ill, the psychiatric-mental health nursing content that precedes the course and that which is to follow it is considered and is one determinant of the competencies for this course or unit.

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CONTENT

In planning for integration, threads of content are identified. The substance of these threads is indicated by the terminal expected competencies. Threads related to psychiatric-mental health nursing content are interwoven throughout the curriculum in the same manner as are other threads.

In identifying the threads of content for the project, the conceptual framework that evolved from consideration of the nature of man in health and in illness was followed as before.

Threads of content that grew out of the project terminal expected competencies--i.e., the nurse-patient relationship, working with groups, and the therapeutic environment--are:

1. Dynamics of individual behavior.
2. Dynamics of communications, both on a one-to-one basis and in small groups.
3. Dynamics of environmental influences.

In order to show progression and at the same time be adaptable to a wide variety of curriculum structures, the content was artificially divided into that which:

1. Precedes the course or unit in nursing care of the mentally ill.
2. Is included in the course or unit.
3. Follows the course or unit.

Once the threads of content have been identified, the levels of progression determined, and the course competencies stated, related course content is then planned in conjunction with the other course content. Learning experiences and evaluation methods are planned concurrently and will be discussed in succeeding sections.

In order to plan for each course, content may next be divided into:

1. Knowledges.
2. Skills and abilities.
3. Attitudes and appreciations.

For the purposes of this study, these terms have been defined as follows:

Content: Matter that is dealt with by, or presented in, a field of study. This matter is specifically stated and is derived from the objectives of the learning experience.

Knowledge: An idea or a phenomenon to which a student has been exposed and which he can remember either by recall or recognition.[1] Frequently manifested by the student's capacity to name, describe, list, state, explain, et cetera.[2]

Skill: A mode of operation and generalized technique for dealing with a problem. Little or no specialized and technical information is required. Although a skill can be learned, its mastery is more dependent upon natural endowment and experience than upon formal education. A skill may also be referred to as an art.[3]

Ability: The student's concurrent utilization of knowledge and skill in a situation different from the one in which learning took place.[4] Frequently manifested by the student's capacity to solve, interpret, apply, work, do, et cetera.[5]

Attitude: A persistent disposition primarily grounded in emotion and expressive of opinions rather than beliefs. Implies action that is either positive or negative, that varies in intensity, and that is directed toward a person, a group, an object, a situation, or a value system.[6] Frequently manifested by what the student enjoys or does not enjoy, chooses to do or not to do, et cetera.[7]

Appreciation: The full awareness, recognition, and just estimation of a thing's worth and scope.

To reiterate, content is developed from each group of competencies; i.e., those related to the nurse-patient relationship, those related to working with groups, and those related to the therapeutic environment, which, in turn, have evolved from the theoretical framework; i.e., the nature of man in health and in illness: (1) in relation to himself, (2) in relation to other men as individuals and in groups, and (3) in relation to the environment. This content is taught concurrently and ultimately is incorporated as an integral yet identifiable aspect of the total content of each course and/or level. Therefore, no one list of content progression is complete in itself while in the developmental stage; it must be looked at in conjunction with the total content for the course and/or level and the content preceding and that succeeding the content in the course and/or level in question.

For this publication, examples of content, learning experiences, teaching tools and methods, and evaluation methods were developed for only one terminal expected competency, "utilizes communication skills knowledgeably," which is related to the nurse-patient relationship. This was done to exemplify the method of content integration. Examples of content progression related to working with groups and the therapeutic environment appear in other project publications.[8]

Following is an example of progression of content within the theoretical framework. From these examples, it can be seen how one area of content related to the nurse-patient relationship has grown out of a competency and is started at the beginning of the nursing curriculum. It demonstrates how the continuity and sequence of content is structured so as to show how foundational content is built upon by subsequent content in order to achieve depth of learning and how significant threads of content are integrated throughout the program of studies in order to bring about both a vertical and a horizontal association of learning experiences.[9] It can also be seen that the content proceeds from simple to complex, normal to abnormal, and obvious to subtle in order to facilitate progression of planning; i.e., the content is based on content from the psychosocial sciences.

Since content from the psychosocial sciences provides a base for psychiatric-mental health nursing content, the content from the courses in general psychology, general sociology, and human growth and development must be reviewed by representatives of the nursing department with the course instructors in light of the nursing department's objectives and the students' educational needs. In this way, the nursing instructors will be familiar with the content in the students' courses in the psychosocial sciences. This process is facilitated by the psychosocial science instructors' being on the curriculum committee of the nursing program as resource people.

Among diploma programs there is a trend toward students' taking their course work in psychology and sociology through a college or university. In this case, nursing faculty may need to provide further mechanisms for familiarizing themselves with the content in these courses.

What content should precede the course or unit in nursing care of the mentally ill?

General areas of content are those related to growth and development of the individual

CONCEPT: Man in Relation to Others--Dynamics of Communication

TERMINAL EXPECTED COMPETENCY: Utilizes Communication Skills Knowledgeably*

I. PRECEDING THE COURSE OR UNIT IN NURSING CARE OF THE MENTALLY ILL

EXAMPLES OF RELATED COURSE OR LEVEL COMPETENCIES	CONTENT		
	Knowledges	Skills and Abilities	Attitudes and Appreciations
Describes theories, components, and purposes of communication	Theories: 1. Ruesch, J. 2. Rogers, Carl Components: 1. Verbal 2. Nonverbal behavior		Appreciates importance of human need to communicate
Observes and describes nonverbal communication	Purposes--goal-directed Patterns--related to personality formation and stage of development	Observation Listening	
Talks with assigned patients for purposes of gathering and/or relaying information relevant to the patient's illness	Principles of: health teaching and learning	Techniques of: 1. Reflective 2. Open-end 3. Directive	

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*See Terminal Expected Competencies Related to the Nurse-Patient Relationship, pages 21-22.

II. INCLUDED IN THE COURSE OR UNIT IN NURSING CARE OF THE MENTALLY ILL

EXAMPLES OF RELATED COURSE OR UNIT COMPETENCIES	CONTENT		
	Knowledges	Skills and Abilities	Attitudes and Appreciations
Attends to the communication of others	Breakdowns in communication	Listens to "tone" as well as words Attempts to view patient's communication from his frame of reference (empathize)	Appreciates effect of own attitudes about mental illness on own communication
Validates the communications of others with them	Barriers to communication: 1.Intrapsychic 2.Interpersonal Symbolization and desymbolization		Appreciates that response of others may be related to own communication
Recognizes prominent themes in communications of others		Problem-solving	
Keeps open the flow of effective communication	Effect of anxiety on ability to communicate	Techniques of facilitating communication	
Tolerates silence	Meanings of silence Use of silence	Deals constructively with own anxiety	

III. FOLLOWING THE COURSE OR UNIT IN NURSING CARE OF THE MENTALLY ILL

EXAMPLES OF RELATED COURSE OR LEVEL COMPETENCIES	CONTENT		
	Knowledges	Skills and Abilities	Attitudes and Appreciations
Application of previously learned knowledges, skills, and abilities in depth to the care of all patients with major health problems			

and general theories of behavior that include anxiety and the defense mechanisms, family relationships, and group dynamics content. These knowledges are reinforced and built on in the area of nursing care of the mentally ill.

The course or unit in nursing care of the mentally ill is used to broaden and deepen the student's interpersonal skills and knowledges about human behavior. It is not used as a basis for these skills and knowledges. The knowledges are introduced in the psychosocial science courses and are integrated as content in the clinical nursing courses. Skills and abilities in these areas are further developed through application of these knowledges in the clinical nursing laboratory.

Other knowledges and abilities that are started at the beginning of the nursing curriculum and included in all nursing courses, including nursing care of the mentally ill, are:

1. Interviewing techniques (communication skills).
2. The problem-solving process.
3. Use of nursing care plan.

What content should be included in the course or unit in nursing care of the mentally ill?

Since the program's aim is to prepare students to function under supervision in a beginning first-level position in all clinical areas, the competencies for the course or unit in nursing care of the mentally ill are consistent with this aim; i.e., they are designed to prepare beginning first-level practitioners in nursing care of the mentally ill.

With the integration of threads of psychiatric-mental health nursing content throughout the curriculum, the major focus of the course or unit in nursing care of the mentally ill is on understanding the dynamics of behavior of the functionally mentally ill and the appropriate nursing care. Considering content prerequisites and the focus of the course or unit, it is placed near the end of the curriculum.

The major content areas in the course or unit are:

1. The dynamics of behavior of the functionally mentally ill.
2. Nursing care of the functionally mentally ill and its underlying rationale.
3. Immediate environmental influences and their effects on the patient.
4. The dynamics of group interactions (patient, nursing team, interdisciplinary team).
5. History of and trends in psychiatry and psychiatric nursing, including the trend toward the development of community mental health centers.
6. Treatment modalities in psychiatry.

The content that follows the course or unit in nursing care of the mentally ill would be designed to provide the student with the opportunity to apply those knowledges and skills learned in depth in the course or unit to the care of all patients with major health problems. More specifically, she would engage in the nurse-patient relationship with those patients found in a general hospital setting with psychosomatic, addictive, and psychoneurotic disorders and with those exhibiting behavior due to organic disorders. In this section, too, she would deepen her skills in working with the nursing and interdisciplinary teams as well as apply her skills with patient groups in the general hospital setting.

Needless to say, in order to plan effectively for progression of content, the faculty will need to work as a group. In this way, they will know the expected competencies and content of each other's courses and so avoid needless duplication and overlapping.

The psychiatric nursing faculty members assume the major responsibility for assisting in the integration of the psychiatric-mental health nursing content in the curriculum. Among diploma programs there is a trend toward employment of instructors in psychiatric nursing by the home school instead of utilizing the traditional affiliation type of arrangements.

In order to be more familiar with the content in psychiatric-mental health nursing for purposes of integration, the faculty would need to plan an inservice education program for themselves. Suggested goals for such a program are to enable the faculty to:

1. Enlarge upon their own skills and knowledges in psychiatric-mental health nursing.
2. View content from the psychosocial sciences as foundational to psychiatric-mental health nursing content.
3. View their own courses as providing a base for and a follow-up of the course in nursing care of the mentally ill.

Through an ongoing faculty inservice education program, each faculty member would ultimately become more knowledgeable in the psychiatric-mental health nursing aspects of the course or courses she teaches, which would enable her to assume the major responsibility for planning and implementing this content as an integral part of the total content in her course.

Having planned for the content in psychiatric-mental health nursing, the faculty is now ready to engage in the next step of implementing the integration process, which is consideration of student learning experiences and teaching tools and methods.

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LEARNING EXPERIENCES AND TEACHING TOOLS AND METHODS

Learning experiences, as stated previously, are planned concurrently with the selection of content. Direction for the selection of learning experiences is provided by the expected competencies. The selection of clinical laboratory facilities to be used for the learning experiences is determined by the objectives of the particular experience, or, when stated behaviorally, by the competencies expected of the student as a result of the particular experience.

Since teaching and learning are correlatives of each other,[1] it follows that the selection of teaching tools and methods is determined by the desired student learning experiences, which, as stated above, have grown out of the expected competencies and are planned concurrently with the content. Course outlines show the relationship between and the concurrency of expected competencies, content, learning experiences (including clinical laboratory experience and clinical conferences), and teaching tools and methods.

Following is a list of pertinent terms as defined for the purposes of this study.

Learning: The acquisition of knowledges, skills, and abilities that results in a change in behavior in the learner. Has the characteristics of being unitary, individual and social in context, self-active, purposive, creative, and transferable.[2]

Learning Experience: The interaction between the learner and the external conditions in the environment to which he can react. These conditions are purposefully planned so as to stimulate the desired reaction in the learner.[3]

Teaching: The imparting of knowledges and techniques through a variety of means both directly (example: instruction) and indirectly (example: role model) in any setting in which there is a recipient (learner). Implies not only instruction but also stimulation, encouragement, and guidance of the student by the teacher.[4] Although the development of abilities, appreciations, and attitudes may be an indirect result of the teaching process, these cannot be directly taught, since their acquisition is dependent upon the capacity of the student to analyze, integrate, evaluate, and internalize his experiences.

Method: An orderly procedure or process; a manner of doing anything. For the purposes of this study, the word method will refer to the manner of instruction and evaluation; for example, lecture, small-group discussion, use of audio-visual aids, critical incident technique, et cetera.

When learning experiences take place in the clinical laboratory, the student may apply her knowledge through the use of the nursing care plan. Patient needs and nursing problems are identified, and appropriate nursing care is planned and then implemented in accordance with the plan.

For the purposes of this study, a nursing care plan[5] is a written evaluation of the patient's individualized nursing care needs, along with suggestions as to how these needs may best be met. Developing a nursing care plan is essentially a problem-solving process and requires that the nurse have ability to:

1. Identify the needs of the patient, including priorities of need.
2. Understand the possible reasons for the existence of these needs.
3. Identify appropriate nursing care, including priorities of care.
4. Understand how and why this nursing care may meet the patient's needs.

The nursing care plan is designed to guide the nurse in giving effective nursing care and is therefore developed prior to the administration of the care. However, the nursing care given on the basis of the initial nursing care plan is evaluated, and the plan is then revised accordingly. In fact, planning nursing care is an ongoing process subject to evaluation and revision as the needs of the patient change, as more information is gathered, and as greater depth of understanding of the patient is attained. Evaluation of the nursing care plan (reporting and describing the nursing care given and the patient's responses) forms the essence of the nurse's notes.

Contributions to the nursing care plan are made by all nursing personnel concerned with the care of the patient, taking into consideration the total plan of care developed by the interdisciplinary team. The use of the nursing care plan by all nursing personnel facilitates communication and continuity of patient care.

Although the nurse and the nursing team may increase their knowledge about a specific patient and their skill in rendering nursing care through the use of a nursing care plan, a nursing care plan is not essentially a teaching tool, but rather, a device designed to help in the provision of consistently effective nursing care to patients. Therefore, it is appropriately used in all instances in which a patient is in need of nursing care services.

Prior to the course or unit in nursing care of the mentally ill, the nursing care given--*i.e.*, the student learning experiences--related to psychiatric-mental health nursing is primarily that of nurse-patient interaction and nursing intervention, which can be seen as directed toward primary prevention and crisis intervention.

> *Problem-Solving* is a kind of learning by means of which principles are put together in chains to form "higher order principles." These become the generalizations that enable the student to think about an ever-broadening set of new problems. Requires the prelearning of concepts and principles, and is manifested by the student's ability to propose and evaluate a solution to a new problem.[6]

The problem-solving method is utilized not only in the nursing care plan but also in the pre- and post-clinical laboratory conferences. The preconference is that time preceding the student's contact with the patient during which she, with guidance and direction from the instructor, explores the objectives of the experience and plans her nursing care. In the postconference, nursing care problems are considered both from the standpoint of the patient's needs and the students' feelings about the patient and his needs.

It is well to separate the student's personal problems from her behavior in the clinical laboratory as related to the patient and from her behavior in the postconference as related to her participation in the student group discussions. Assistance for personal problems is given by counselors in the guidance program. The guidance program is under the direction of a qualified person and is separate from the instructional program. An exception is academic counseling, in which case it is appropriate for instructional personnel to be involved.

Another teaching device that can be used as a tool in teaching interpersonal relationships is the *process recording*. A process recording[7] is an exact written account of the verbal and nonverbal interaction between the nurse and the patient during a specified period of time. It includes an objective account of what the patient said and did and what the nurse said and did. This is followed by an analysis of what the nurse believes to have been the meaning of the interaction, including her feelings and those that she thinks the patient may have experienced.

It is helpful if the process recording is written in columns, as this format facilitates appreciation of both the vertical and the horizontal association of aspects of the interaction. In addition, sufficient space should be allowed for the instructor to write comments.

It is mandatory that a process recording be not only reviewed by the instructor but also discussed with the student on an individual basis in conference.

A process recording is written as soon after the interaction as possible in order to minimize the margin of error. It is rarely written during the interaction. This is not to say that the fact that process recordings are being kept should be hidden from the patient, but rather, that the nurse should be free from all distractions during the interaction. The patient needs to be assured both verbally and by her manner that the nurse will abide by the principles of confidentiality.

A well-done process recording is very valuable in helping the nurse to identify themes in both her behavior and that of the patient. Also, it helps the nurse to evaluate the progress of the nurse-patient relationship and to plan for its continuation. Each process recording can provide one basis upon which the over-all nursing care plan is revised in preparation for the next interaction with the patient.

As a teaching-learning tool, the process recording is useful in learning dynamics of human behavior, interpersonal relations, communication skills, self-awareness, et cetera, and can be useful in any nurse-patient interaction at any point in the curriculum. The use of this tool can commence with the first clinical nursing course but in the form of simple records of the interaction,known as interaction notes.

If the student had experience with interaction notes when studying nurse-patient interactions prior to the course or unit in nursing care of the mentally ill, she should be quite adept at executing the mechanics of the process recording when studying the nurse-patient relationship in the course or unit in nursing care of the mentally ill.

The most extensive use of the process recording will most likely be in the course or unit in nursing care of the mentally ill, since the primary focus of this course or unit is the interaction process. In addition, at this time the student will acquire a greater depth of knowledge about behavior, which will enable her to analyze the interaction more accurately and in greater depth than she had previously been able to do.

Prior to the use of this tool, its purpose should be thoroughly explained to the student and its use should be clearly related to the objectives of the experience. Purposeful or inadvertent censoring of the record by the student cannot, in most instances, be prevented. However, this should not be the cause of undue concern to the instructor, since the recognition by the student of what might have been a more appropriate response or behavior on her part indicates that learning must have taken place. Undue pressure on the student to be "right" at all times can be avoided to some degree if the process recording is not graded.

Psychiatric-mental health nursing faculty members participate in the clinical laboratory learning experiences of all nursing courses as resource people and/or in a team-teaching relationship.

After the expected competencies are determined for the course or unit in nursing care of the mentally ill and the content and learning experiences are planned, the clinical laboratory facilities are then selected on the basis of the objectives of the learning experiences. When it has been determined that an agency can provide clinical experiences that will enable the student to achieve the objectives of the experience, the following factors[8] need to be considered in the final selection of an agency.

1. Agency interest in having the students.
2. Distance of the agency from the program.
3. Accreditation status of the agency.
4. Philosophy of care of the agency.
5. Objectives of nursing service.
6. Patient census.
7. Variety and stages of illness of the patients.
8. Number and qualifications of nursing staff.
9. Number and preparation of medical and allied staff.
10. Interdisciplinary cooperativeness.
11. Variety of facilities and services.
12. Inservice education program for all levels of personnel.
13. Training programs for other disciplines.
14. Ongoing research projects.
15. Space for conferences.
16. Adequacy of library facilities.
17. Adequacy of nursing records and patient care plans.
18. Availability of medical records.

In order for the course or unit in nursing care of the mentally ill to include consideration of the problem of mental illness as it affects and is dealt with by the community, appropriate clinical facilities and agencies are used for supplementary clinical laboratory experience in addition to psychiatric hospitals and psychiatric units in general hospitals. Such other facilities include:

1. Out-patient services.
2. Day and night hospitals.
3. Welfare agencies, et cetera.
4. Schools.
5. Rehabilitation facilities--vocational, educational, social.
6. Aftercare services--home visits, foster home placement, nursing homes, halfway houses.

Objectives are written for field trips and observation experiences in the same way as they are written for a regular clinical laboratory experience.

In the clinical laboratory, each student must have the opportunity to work with and study one patient over a period of time under supervision in addition to working with a small group of patients. In her nurse-patient relationship, she communicates with other appropriate health workers. In order for the student to receive adequate supervision in the nurse-patient relationship, the faculty-student ratio is not more than 1:10.

The problem-solving method is utilized in the clinical laboratory in the course or unit in nursing care of the mentally ill. Small-group pre- and post-conferences, nursing care plans, and process recordings are the primary methods of instruction as in laboratory experiences in other nursing courses. Also, as before, course outlines show the relationship between and the concurrency of expected competencies, content, learning experiences (including clinical laboratory experience and clinical conferences), and teaching tools and methods.

Although there is a trend among diploma programs toward the school's employing an instructor in psychiatric nursing who is responsible for the course, some schools still maintain the traditional affiliation type of arrangement. In these instances, the objectives of the course in nursing care of the mentally ill must be jointly planned. In addition, the instructors from the cooperating agency should participate in total curriculum planning in the home school. In this manner, both faculties will be familiar with the content taught in each institution, so that they can provide for progression of content in depth and sequence and, at the same time, avoid duplication and overlapping. Some provision should be made for orientation for students in advance of their experience in nursing care of the mentally ill, especially if an affiliation type of arrangement is utilized.

Needless to say, instructors in affiliation programs should be responsible not only for the classroom teaching but also for the direct clinical supervision of students, including evaluation. Resource people, such as physicians, et cetera, are used only for specific topics and not as major lecturers.

When an agency is used regularly to provide clinical laboratory experience for students, a contract between the school and the agency is written. This contract should include:

1. The nature and extent of the responsibility assumed by the nursing school or department.
2. The nature and extent of the responsibility assumed by the clinical agency.
3. The facilities provided by the agency, including clinical laboratory experiences, adequate and appropriate space for conferences, locker space, et cetera.
4. The responsibility for instruction of the students, both in the classroom and in the clinical laboratory.
5. The amount of clinical laboratory experience to be made available to or provided for students (days and weeks).
6. The financial arrangement.

The contract should be reviewed periodically by appropriate representatives from both the school and the agency.

Following is an example of how learning experiences and teaching tools and methods are derived from and made consistent with the expected competencies and content. The example builds upon that which appears in the preceding section.

CONCEPT: Man in Relation to Others--Dynamics of Communication

TERMINAL EXPECTED COMPETENCY: Utilizes Communication Skills Knowledgeably*

I. PRECEDING THE COURSE OR UNIT IN NURSING CARE OF THE MENTALLY ILL

EXAMPLES OF RELATED COURSE OR LEVEL COMPETENCIES	CONTENT			LEARNING EXPERIENCES	TEACHING TOOLS AND METHODS
	Knowledges	Skills and Abilities	Attitudes and Appreciations		
Describes theories, components, and purposes of communication	Theories: 1. Ruesch, J. 2. Rogers, Carl		Appreciates importance of human need to communicate		Lecture Discussion
	Components: 1. Verbal 2. Nonverbal behavior			Writes and implements a nursing care plan for a patient whose needs are expressed predominantly through nonverbal communication	Preconference Acts as a role model
Observes and describes nonverbal communication	Purposes--goal-directed Patterns--related to personality formation and stage of development	Observation Listening		Plans for and engages in selected interactions with patients whose needs include health teaching; writes interaction notes on these interactions	Review of interaction notes with student in individual conference
Talks with assigned patients for purposes of gathering and/or relaying information relevant to the patient's illness	Principles of: health teaching and learning	Techniques of: 1. Reflective 2. Open-end 3. Directive		Postconference	

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*See Terminal Expected Competencies Related to the Nurse-Patient Relationship, pages 21-22.

II. INCLUDED IN THE COURSE OR UNIT IN NURSING CARE OF THE MENTALLY ILL

EXAMPLES OF RELATED COURSE OR UNIT COMPETENCIES	CONTENT			LEARNING EXPERIENCES	TEACHING TOOLS AND METHODS
	Knowledges	Skills and Abilities	Attitudes and Appreciations		
Attends to the communication of others	Breakdowns in communication	Listens to "tone" as well as words Attempts to view patient's communication from his frame of reference (empathize)	Appreciates effect of own attitudes about mental illness on own communication	Writes a plan for and engages in a supportive nurse-patient relationship with one selected patient who has difficulty in communicating	Preconference Acts as a role model
Validates the communications of others with them	Barriers to communication: 1. Intrapsychic 2. Interpersonal		Appreciates that response of others may be related to own communication	Ongoing process recording Postconference	Review of process recording with student in individual conference
Recognizes prominent themes in communications of others	Symbolization and desymbolization	Problem-solving			
Keeps open the flow of effective communication	Effect of anxiety on ability to communicate	Techniques of facilitating communication			
Tolerates silence	Meanings of silence Use of silence	Deals constructively with own anxiety			

III. FOLLOWING THE COURSE OR UNIT IN NURSING CARE OF THE MENTALLY ILL

EXAMPLES OF RELATED COURSE OR LEVEL COMPETENCIES	CONTENT			LEARNING EXPERIENCES	TEACHING TOOLS AND METHODS
	Knowledges	Skills and Abilities	Attitudes and Appreciations		
Application of previously learned knowledges, skills, and abilities in depth to the care of all patients with major health problems				Writes and implements a nursing care plan for a selected patient whose needs are complex; i.e., overt and covert and long-term in nature Engages in nursing interventions Process recording Postconference	As above

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EVALUATION METHODS

Having developed the appropriate teaching tools and methods, the faculty is now ready to proceed with the consideration of methods of evaluation. Evaluation methods, as stated previously, are planned concurrently with the content, learning experiences, and teaching tools and methods. All grow out of the expected competencies. To the degree that expected competencies are stated in behavioral terms, evaluation methods are implied. The expected competencies also provide direction for determination and evaluation of the level of achievement of the student. They must be expressive of behaviors in which every student will have had the opportunity to engage.

The following are relevant terms as defined for the purposes of this study.

Evaluation: A process for determining to what extent the learning experiences as developed and organized are actually producing the desired results. Implied in the term are: (1) an appraisal of the entering behavior of the students, since it is change in this behavior that is sought in education; (2) more than a single appraisal at any one time, since in order to see whether change has taken place, it is necessary to make an appraisal at an early point and other appraisals at later points to identify changes that may be occurring.[1]

Entering Behavior: Certain knowledges and skills manifested in behavior that are prerequisite to a new sequence of instruction and learning.[2]

Level of Achievement: A position or rank in a progression of steps derived from the objectives of the learning experience and resulting in a terminal expected competency. A student's level of achievement is manifested in his behavior.

Terminal Expected Competency: The description of the desired outcome(s) of a program of studies, a course, or any given learning experience. It is stated in behavioral terms describing the expected performance of the student that has been established as the minimal acceptable level of achievement at the end of a planned unit of instruction and indicating that the learner has achieved the objective(s); i.e., there has been a behavioral change in the student. It is derived from and consistent with the philosophy of the program.[3] The term terminal expected competency is used interchangeably with the term terminal behavior.

As stated earlier, the terminal expected competencies are the curriculum objectives stated in behavioral terms and need to be broken down into level and/or course competencies. These competencies may reflect a combination of student knowledges, skills and abilities, and attitudes and appreciations, or any one of these components. The method of evaluation used needs to be appropriate to the component or combination of components reflected in the competency.

Of these components, knowledges are the most directly measurable and therefore the most easily and accurately evaluated. Attitudes and appreciations, on the other hand, are the least directly measurable and must be evaluated inferentially from observable behavior. Evaluation of attitudes and appreciations, therefore, is not as precise as is evaluation of knowledges but must be of concern to the instructor insofar as they affect the student's nursing care.

Between these two extremes is the evaluation of skills and abilities, which are ultimately of primary concern in the practice of nursing. Therefore, the following discussion is limited to evaluation of skills and abilities in the psychiatric-mental health nursing aspects of all patient care.

When evaluating a student's ability in psychiatric-mental health nursing as manifested in her nursing care of all patients, both physically and mentally ill, general principles of student evaluation need to be followed. For example, since a student is evaluated only in terms of the objectives (expected competencies) of the learning experience or experiences, adequate opportunity must have been provided for the student to have learned and practiced the ability stated in the competency prior to the time she is evaluated. The student is made aware of the fact that she is being evaluated, and the result of the evaluation is discussed with her by the instructor and is used as one basis for planning further learning experiences for the student.

In addition to these and other well-known principles of student evaluation to which the instructor adheres, the instructor who is evaluating a student's ability in psychiatric-mental health nursing must of necessity make inferences as to the meaning of observable student behavior. These inferences are necessitated by the fact that the expected competencies in psychiatric-mental health nursing are most frequently qualitative rather than quantitative in nature. For example, the primary concern is, not merely to ascertain whether or not a student sits and communicates with her assigned patient, but to determine the quality of the communication; *i.e.*, was it planned purposefully? Was it helpful to the patient? And so on.

Some faculty are hesitant to evaluate any student behavior other than that which can be *directly* measured. However, if students are to be taught nursing care measures not amenable to direct measurement--*e.g.*, nursing interaction and the nurse-patient relationship--the instructor then has the right and the responsibility to evaluate the student in light of the stated expected competencies for these measures. She has this right and responsibility by virtue of her role as teacher. This is not meant to imply that her title alone gives her the authority to pass judgment on students in an arbitrary manner, but rather, that her expertise in nursing practice and nursing education that qualified her to become an instructor in the first place also qualify her to evaluate student learning as manifested by the nursing care given by the student. Only if the instructor assumes this responsibility will the teaching and learning of skills and abilities in nursing assume the characteristics of an educational process.

One method of evaluation of skills and abilities is the use of critical incidents. The following definitions have been adopted for the purposes of this study.

Incident: Any observable type of human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the person performing this act.[4]

Critical Incident: A technique for evaluating clinical performance. Critical incidents are those behaviors that have been found to make the difference between success and failure in carrying out an important part of a specific assignment. Such incidents are crucial in the sense that they have been responsible for outstandingly effective or definitely unsatisfactory performance of an important part of the job or activity in question.[5]

The crucial elements of a job or activity (critical incidents) are determined by experts in the field. Inherent in the determination of a critical incident is that it occurs frequently. When the critical incident is used as an evaluation device, every student must have the opportunity to engage in the act under question.

> However, only those students at the extremes of performance will be differentiated by this technique. Evaluation of student performance by means of the critical incident technique must be done by experts in the field.

The faculty arrives at that which they agree upon as being a critical incident by breaking down each group of expected competencies into their essential elements. Which, if any, of these elements are crucial to the successful performance of the task can be determined by the faculty's writing and collecting anecdotal records of student performance in relation to the elements of the competencies in question. After a large number of records on a variety of students has been amassed (which may require several years in programs where the student body is small), these records are then divided into three groups by correlating them with the grade of the over-all performance of each student. These groups are: (1) records of students whose performance was superior, (2) records of students whose performance was average, and (3) records of students whose performance was inferior. The anecdotal records of the average students are then discarded. The two remaining groups of records are examined in an effort to identify recurring themes or patterns of student behavior. These behaviors can then be reasonably considered to be the critical elements of the task in question and used for future student evaluation.

When critical incidents are used as an evaluation device, students are scored as either passing or failing, since the incident deemed truly critical leaves no room for variation in performance. Obviously, then, it is understandable that a faculty may agree upon relatively few aspects of nursing care as being critical incidents as described here.

Critical incidents are stated behaviorally in positive terms. They are used most effectively as an evaluation device by those instructors who are experts in the area of nursing being evaluated, since, once again, inferences must frequently be made as to the meaning of observable student behavior.

Faculties who have identified and use critical incidents for the purpose of student evaluation often find that those student behaviors deemed crucial are concerned with the safety of the patient. For example, a critical incident might be:

> The student raises the side of the toddler's crib before she leaves him after giving nursing care.

This student behavior is directly observable and its relevance to the safety of the patient is obvious.

However, when one moves into the area of psychiatric-mental health nursing, those elements that are crucial to the emotional safety of the patient become controversial and difficult for a faculty to ascertain, much less agree upon. Therefore, the previously described technique for determining critical incidents becomes particularly helpful. In addition, those factors considered to impair the emotional safety of the patient will depend very much on the faculty's philosophy of nursing, including psychiatric-mental health nursing aspects.

Following are some examples of possible critical incidents that show progression in depth and complexity:

> The student introduces herself to the patient at the time of their first meeting.
> The student adheres to the principles of confidentiality in relating and relaying information concerning the patient.
> The student promises and fulfills only those behaviors that are appropriate in the context of the nurse-patient relationship.
> The student remains with the anxious patient when this action would benefit him.

Not considered in this section are commonly used student evaluation methods, such as paper-and-pencil tests, written reports, return demonstrations, self-evaluation, et cetera. Suffice it to say, as when used in any other area, the principles underlying the uses of these methods are the same and apply when evaluating the student's knowledges and skills in the psychiatric-mental health nursing aspects of all nursing care. It is the responsibility of the faculty to develop the specific tools required to implement the evaluation method indicated by the expected competency.

Shown on pages 43 and 44 is an example of a completed chart showing the development of selected course or level competencies related to one terminal expected competency that, in turn, is one aspect of the terminal expected competencies related to the nurse-patient relationship. All have evolved from an over-all conceptual framework. Indicated in the chart are vertical progression and horizontal association of competencies, content, learning experiences, teaching tools and methods, and evaluation methods.

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CONCEPT: Man in Relation to Others--Dynamics of Communication

TERMINAL EXPECTED COMPETENCY: Utilizes Communication Skills Knowledgeably*

I. PRECEDING THE COURSE OR UNIT IN NURSING CARE OF THE MENTALLY ILL

EXAMPLES OF RELATED COURSE OR LEVEL COMPETENCIES	CONTENT			LEARNING EXPERIENCES	TEACHING TOOLS AND METHODS	EVALUATION METHODS
	Knowledges	Skills and Abilities	Attitudes and Appreciations			
Describes theories, components, and purposes of communication	Theories: 1. Ruesch, J. 2. Rogers, Carl		Appreciates importance of human need to communicate		Lecture Discussion	Paper-and-pencil tests
	Components: 1. Verbal 2. Nonverbal behavior			Writes and implements a nursing care plan for a patient whose needs are expressed predominantly through nonverbal communication	Preconference Acts as a role model	Teacher observation of student-patient contact as related to stated competencies
Observes and describes nonverbal communication	Purposes--goal-directed Patterns--related to personality formation and stage of development	Observation Listening		Plans for and engages in selected interactions with patients whose needs include health teaching; writes interaction notes on these interactions	Review of interaction notes with student in individual conference	Student's verbal and written reports of student-patient contact as related to stated competencies
Talks with assigned patients for purposes of gathering and/or relaying information relevant to the patient's illness	Principles of: health teaching and learning	Techniques of: 1. Reflective 2. Open-end 3. Directive		Postconference		

*See Terminal Expected Competencies Related to the Nurse-Patient Relationship, pages 21-22.

II. INCLUDED IN THE COURSE OR UNIT IN NURSING CARE OF THE MENTALLY ILL

EXAMPLES OF RELATED COURSE OR UNIT COMPETENCIES	CONTENT			LEARNING EXPERIENCES	TEACHING TOOLS AND METHODS	EVALUATION METHODS
	Knowledges	Skills and Abilities	Attitudes and Appreciations			
Attends to the communication of others	Breakdowns in communication	Listens to "tone" as well as words Attempts to view patient's communication from his frame of reference (empathize)	Appreciates effect of own attitudes about mental illness on own communication	Writes a plan for and engages in a supportive nurse-patient relationship with one selected patient who has difficulty in communicating	Preconference Acts as a role model	Teacher observation of student-patient contact as related to stated competencies
Validates the communications of others with them	Barriers to communication: 1. Intrapsychic 2. Interpersonal Symbolization and desymbolization		Appreciates that response of others may be related to own communication	Ongoing process recording Postconference	Review of process recording with student in individual conference	Student's verbal and written reports of student-patient contact as related to stated competencies
Recognizes prominent themes in communications of others		Problem-solving				
Keeps open the flow of effective communication	Effect of anxiety on ability to communicate	Techniques of facilitating communication				
Tolerates silence	Meanings of silence Use of silence	Deals constructively with own anxiety				

III. FOLLOWING THE COURSE OR UNIT IN NURSING CARE OF THE MENTALLY ILL

EXAMPLES OF RELATED COURSE OR LEVEL COMPETENCIES	CONTENT			LEARNING EXPERIENCES	TEACHING TOOLS AND METHODS	EVALUATION METHODS
	Knowledges	Skills and Abilities	Attitudes and Appreciations			
Application of previously learned knowledges, skills, and abilities in depth to the care of all patients with major health problems				Writes and implements a nursing care plan for a selected patient whose needs are complex; i.e., overt and covert and long-term in nature Engages in nursing interventions Process recording Postconference	As above	As above

EVALUATION OF THE INTEGRATION OF PSYCHIATRIC-MENTAL HEALTH NURSING CONTENT THROUGHOUT THE CURRICULUM AND OF THE COURSE OR UNIT IN NURSING CARE OF THE MENTALLY ILL

Determining the effectiveness of integration of psychiatric-mental health nursing content and the course or unit in nursing care of the mentally ill is the responsibility of the faculty. The evaluation is based upon the objectives for integration and the course or unit that the faculty has previously stated. (See page 8.) Informal ongoing evaluation takes place continuously. In addition, a specific period of time should be set aside for the purpose of program evaluation. Since the curriculum operates as a whole and changes or modifications will therefore influence the total program, and since the integration of psychiatric-mental health nursing content throughout the curriculum and the course or unit in nursing care of the mentally ill have been developed as an integral part of the total curriculum, evaluation of the integration and the course cannot be assessed in isolation, but must be a part of total curriculum evaluation.

Before the faculty begins the formal evaluation process, they need to discuss and agree upon the purpose of the evaluation. Ideally, the faculty views all aspects of program evaluation as a means through which program improvement can be achieved. Specifically, the faculty would want to determine whether or not they have achieved their objectives for integration in the curriculum and for the course or unit in nursing care of the mentally ill.

After the faculty agrees upon the necessity for and the purpose of program evaluation, the next step is to review the philosophy and objectives. Do all faculty members both understand and agree with the philosophy and objectives? Does the philosophy include reference to the faculty's belief about the nature of man, nursing practice, education in general, and nursing education specific to the level of function for which students are being prepared? Do the philosophy and objectives reflect current trends in both nursing education and nursing practice? Do they reflect the belief that quality nursing care of all patients includes not only the biophysical aspects but also the psychosocial aspects? Do they reflect the belief that the program prepares beginning first-level practitioners in nursing care of patients with major health problems, including mental illness?

The next step is to review the curriculum. Is the curriculum structure a logical outcome of the beliefs stated in the philosophy and of the goals stated in the objectives? For example, if the faculty believes that learning best takes place when content proceeds from normal to abnormal, the curriculum structure should show course sequence as an outgrowth of this belief; e.g., courses in psychology, sociology, anatomy and physiology, microbiology, et cetera, should be offered early in the curriculum so that this content can be used subsequently as a foundation for both nursing and other courses. Can the faculty justify on the basis of their philosophy the rationale underlying the inclusion of the various courses and perhaps the exclusion of others?

The next step is to review the competencies, content, learning experiences, teaching tools and methods, and evaluation methods. These, as stated in previous sections of this publication, should be a direct outgrowth of and be consistent with the philosophy and objectives.

Do the competencies reflect a sequential development of abilities related to psychiatric-mental health nursing aspects of patient care in all settings? Are content and learning experiences so arranged as to realistically allow the student to achieve the abilities referred to in the competencies?

In many instances, the faculty will have been involved in an inservice education type of program designed to enhance their knowledge and skills related to curriculum development. If this was the case, it would be appropriate at this point for the faculty to assess the effectiveness of this program. The assessment is made in light of the objectives the faculty developed for themselves for this program. Frequently, these objectives indicate faculty learning and development as manifested in changes in the curriculum structure, course content, learning experiences, teaching tools and methods, or student evaluation methods. Insofar as this is the case, evaluation of the faculty inservice program is an integral part of curriculum and program evaluation. For example, one goal for the faculty inservice program might be to enable the faculty to view their own courses as providing a base for and follow-up of the course in nursing care of the mentally ill. If this goal was really achieved, then one would see evidence of this not only in the curriculum structure but also in the content and learning experiences of each course for which the individual faculty members are responsible.

The final step in evaluation of the integration and the course as part of the total program evaluation is student evaluation. Students will have been evaluated previously in light of the competencies for each course and/or level. However, the primary purpose of this evaluation is to determine the level of achievement of each individual student. When taken collectively, these student evaluations can be used as an index to determine the effectiveness of the curriculum or any of its aspects.

Implied in student evaluation is an indirect assessment of the nursing care that graduates of the program can reasonably be expected to render in the employment situation. These judgments can be validated to some degree by the use of well-constructed follow-up questionnaires directed both to the graduate and to her employer.

The significance of this last step in the over-all program evaluation--*i.e.*, the extrapolation of the quality of nursing care the graduate can be expected to render--must not be minimized. This is true since the education of nurse practitioners who provide quality nursing care to patients with major health problems is the justification for the existence of the nursing program in the first place.

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APPENDIX B. OPERATIONAL DEFINITIONS

The definitions given below are an attempt to bring together in one place the precise meanings of the technical terms as used in this project. The definitions are derived from recognized authorities in education and nursing. Where these are quoted verbatim or are paraphrased closely, references are cited in the usual way. In other cases, we have freely paraphrased the words of several authorities but are still able to cite chapter and page of particular works. Frequently, however, a definition combines elements from a number of different sources, elements so interwoven that definite attribution can no longer be made. In such cases, our references become bibliographic lists rather than citations. In all other cases, the dictionary consulted in formulating the definitions was Webster's New Collegiate Dictionary. Springfield, Mass., G. & C. Merriam Company, 1960. In definitions of general educational terms, masculine personal pronouns are used; in definitions of nursing terms, feminine pronouns are used for the nurse and masculine for the patient. An asterisk before a term indicates that the definition has been revised since its appearance in the Workshop Report.

Ability: The student's concurrent utilization of knowledge and skill in a situation different from the one in which learning took place.[1] Frequently manifested by the student's capacity to solve, interpret, apply, work, do, et cetera.[2] See also Knowledge, Skill.

Appreciation: The full awareness, recognition, and just estimation of a thing's worth and scope. See also Attitude, Value.

Attitude: A persistent disposition primarily grounded in emotion and expressive of opinions rather than beliefs. Implies action that is either positive or negative, that varies in intensity, and that is directed toward a person, a group, an object, a situation, or a value system.[3] Frequently manifested by what the student enjoys or does not enjoy, chooses to do or not to do, et cetera.[4] See also Appreciation, Value.

*Beginning First-Level Practitioner: For the purposes of this study, the term first-level practitioner designates a nurse who administers direct nursing care; i.e., performs intermediate nursing functions[5] requiring skill and some judgment, in the presence or at the bedside of the patient who is under the care of a physician.[6] She is a contributing member of the nursing team and works under the supervision of a nurse with broad professional preparation.[7] She assumes some responsibility for the direction and supervision of those ancillary personnel who are members of the same team.

A beginning first-level practitioner is a technical nurse who has graduated from a state-approved diploma school or associate degree program of nursing, is eligible for licensure or is currently licensed in the state in which she practices, and has had less than one year's work experience in nursing after graduation.

See also Nursing, Technical Occupation.

*Beginning First-Level Practitioner in Nursing Care of the Mentally Ill: For the purposes of this study, the term first-level practitioner in nursing care of the mentally ill designates a nurse who administers direct supportive nursing care to the mentally ill patient on a one-to-one or small-group basis. Direct supportive nursing care is rendered in the daily living situation in which the nurse and patient find themselves and is consistent with the over-all treatment goal for the patient determined by the interdisciplinary team. The nurse focuses on strengthening the patient's areas of health and deals only with those thoughts and feelings that the patient brings up and with his behavior. Her nursing care is purposeful and planned, and although it may take many forms, it is based on her knowledges, skills, abilities, attitudes, and appreciations about the behavioral manifestations of the major forms of mental illness. Her primary therapeutic tool in her interactions with patients is "use of self."

In all her activities, the first-level practitioner in nursing care of the mentally ill functions under the supervision of a nurse with broad professional preparation in nursing or a professional psychiatric nurse. She is a contributing member of the nursing team and also functions as such on the interdisciplinary team as it establishes and implements total treatment plans for the patient.

A beginning first-level practitioner in nursing care of the mentally ill is a technical nurse who has graduated from a state-approved diploma school or associate degree program of nursing, is eligible for licensure or is currently licensed in the state in which she practices, and has had less than one year's work experience after graduation in nursing care of the mentally ill.

See also Ability, Appreciation, Attitude, Knowledge, Psychiatric Nursing, Skill, Supportive Nursing Care, Technical Occupation, Therapeutic Use of Self.

Behavior: Mode of conducting oneself; the way in which a person acts in response to a stimulus. See also Entering Behavior, Expected Competencies, Level of Achievement, Terminal Expected Competency.

Communication: All the modes of behavior that one individual employs consciously or unconsciously to affect another--not only the spoken and the written word but also gestures, body movements, somatic signals, and symbolism in the arts. "Non-verbal communication, as a matter of fact, is considered to be a more reliable expression of true feelings than verbal, because the individual has less conscious control over his non-verbal behavior."[8]

Functions of human communication serve the purpose of mediating information across the boundary lines of the human organism or the group organization. Specifically, they solve the problem of how events outside an organism or an organization are represented in terms of information on the inside and how events on the inside are relayed to the outside. The functions of communication include:

1. Perception (the reception of incoming signals).
2. Evaluation (which involves memory and the retention of past experiences as well as decision-making).
3. Transmission and expression of information.

People communicate by making statements. These statements are signals that are coded in various prearranged ways. When they impinge upon earlier impressions, they become signs. These signs, in the strictest sense of the word, exist only in the minds of people, because their interpretation is based upon prior agreements. A statement becomes a message when it has been perceived and interpreted by another person. Finally, when sender and receiver can consensually validate an interpretation, then communication has been successful.[9]

Concept: A class of a number of objectives, events, things, and behaviors that differ in appearance. A mental image of a thing formed by generalization from particulars. E.g.: chair, house, round, tall. Concept achievement is observed when the student becomes capable of responding to different objects (events and behaviors) as if he were placing them in one or more classes (classifying them into one or more categories).[10] See also Principle, Problem-Solving, Theory.

Content: Matter that is dealt with by, or presented in, a field of study. This matter is specifically stated and is derived from the objectives of the learning experience. Not to be confused with Concept (which see). See also Descriptive Approach, Dynamic Approach.

Critical Incident: A technique for evaluating clinical performance. Critical incidents are those behaviors that have been found to make the difference between success and failure in carrying out an important part of a specific assignment. Such incidents are crucial in the sense that they have been responsible for outstandingly effective or definitely unsatisfactory performance of an important part of the job or activity in question.[11]

The crucial elements of a job or activity (critical incidents) are determined by experts in the field. Inherent in the determination of a critical incident is that it occurs frequently. When the critical incident is used as an evaluation device, every student must have the opportunity to engage in the act under question. However, only those students at the extremes of performance will be differentiated by this technique. Evaluation of student performance by means of the critical incident technique must be done by experts in the field.

See also Evaluation, Incident.

Descriptive Approach: Recounts, characterizes, or classifies the material of a field of study. See also Content, Dynamic Approach.

Dynamic Approach: The interaction of forces that results in change. For the purposes of this study, emphasis will be placed on environmental, intrapersonal, and interpersonal forces. Consideration is given to the identification and explanation of the forces underlying behavior, situations, et cetera.[12] See also Content, Descriptive Approach.

Entering Behavior: Certain knowledges and skills manifested in behavior that are prerequisite to a new sequence of instruction and learning.[13] See also Behavior, Expected Competencies, Level of Achievement, Terminal Expected Competency.

Evaluation: A process for determining to what extent the learning experiences as developed and organized are actually producing the desired results. Implied in the term are: (1) an appraisal of the entering behavior of the student, since it is change in this behavior that is sought in education; (2) more than a single appraisal at any one time, since in order to see whether change has taken place, it is necessary to make an appraisal at an early point and other appraisals at later points to identify changes that may be occurring.[14] See also Behavior, Entering Behavior, Expected Competency, Level of Achievement, Terminal Expected Competency.

Expected Competencies:[15] A description of the desired outcome(s) of a program of studies, a course, or any given learning experience. They are stated in behavioral terms that describe what the learner is to be like as a result of the learning experience. They indicate the minimal acceptable level of achievement and are derived from and consistent with the philosophy of the program. See also Behavior, Entering Behavior, Level of Achievement, Terminal Expected Competency.

External Environment: The aggregate of all the conditions and influences, animate and inanimate, tangible and intangible, outside the living organism that affect its life and development. See also Internal Environment.

Incident: Any observable type of human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the person performing this act.[16] See also Evaluation, Critical Incident.

*Integration: "The process of forming new, larger, and more comprehensive whole responses by which differentiated objects and activities are apprehended. It is the combining of details which emerge from larger wholes and ultimately acquire such a degree of individuality and specificity that they are united with other particulars and are reorganized into a coherent pattern."[17] For the purposes of this study, the learning experiences provided by the instructor will be such that content from psychology and sociology as well as psychiatric-mental health nursing content will be interwoven throughout the clinical courses in the nursing curriculum. While learning experiences that facilitate integration of content are provided by the instructor, the process of integration takes place within the student. See also Content, Learning Experience, Psychiatric-Mental Health Nursing Content.

Interaction: Mutual or reciprocal action or influence that produces an effect, especially a change in the condition of something.

Internal Environment: The aggregate of all the conditions and influences within the living organism that affect its life and development. See also External Environment.

Interpersonal Relationship:[18] An interaction (which see) between the individual and his external environment (which see) that is influenced by previous experiences with other persons and objects in the external environment. Although it is recognized that the individual reacts to inanimate objects in the physical setting, for the purposes of this study, emphasis will be placed on the individual's interaction with one or more persons in his social milieu. The individuals involved in an interpersonal relationship interact as participants and as observers, each assuming an active part in a particular situation by observing the response of the other and reacting on the basis of this observation. See also Intrapersonal Relationship, Relationship.

Intrapersonal Relationship:[19] Phenomena, experiences, or interactions occurring within the individual and ultimately affecting his behavior. This behavior is determined in part by the individual's past experience with intrapersonal relationships. Intrapersonal relationships are continuous and therefore occur during all interpersonal relationships, thereby affecting and being affected by them. For the purposes of this study, the term intrapersonal relationship shall be used interchangeably with the terms intrapersonal interaction and and intrapersonal experience. See also Interaction, Interpersonal Relationship, Relationship.

Knowledge: An idea or a phenomenon to which a student has been exposed and which he can remember either by recall or recognition.[20] Frequently manifested by the student's capacity to name, describe, list, state, explain, et cetera.[21] See also Ability, Skill.

Learning: The acquisition of knowledges, skills, and abilities (which see) that results in a change in behavior in the learner. Has the characteristics of being unitary, individual and social in context, self-active, purposive, creative, and transferable.[22] See also Learning Experience.

Learning Experience: The interaction between the learner and the external conditions in the environment to which he can react. These conditions are purposefully planned so as to stimulate the desired reaction in the learner.[23] See also Interaction, Learning, Teaching.

*Level of Achievement: A position or rank in a progression of steps derived from the objectives of the learning experience and resulting in a terminal expected competency. A student's level of achievement is manifested in his behavior. See also Behavior, Entering Behavior, Expected Competencies, Terminal Expected Competency.

Mental Health: A state of being resulting from a personality that is organized in a manner that:

1. Is acceptable to the individual.
2. Results in optimum growth and development, or self-actualization. -
3. Enables the person to function autonomously.
4. Enables the person to perceive reality with minimal distortion.
5. Enables the person to achieve mastery over his environment.
6. Enables the person to have positive affective relationships.

This personality organization is manifested by, and inferred from, patterns of behavior. Mental health has no absolute inherent value. Therefore, when concerned with evaluating the degree of mental health achieved by a person, consideration must be given to standards set by the culture in which he lives and his total personality structure. The above criteria are interdependent and are guides rather than rules for the assessment of the degree of mental health manifested by an individual.[24]

See also Mental Illness.

Mental Illness:[25] A state of being of a living human organism manifested by, and inferred from, his patterns of behavior. Behavior considered to be indicative of mental illness is determined in part by the individual's total personality organization and the values held by the culture to which the individual belongs. Therefore, "mental illness" is not an absolute concept, but a state that varies from individual to individual and from culture to culture. It is also not absolute in the sense that no person is totally mentally ill, but rather manifests behavior indicative of varying degrees of health and illness.

Generally, then, mental illness is a behavioral manifestation of the degree to which the individual's reaction to himself and his interaction with others and the environment are inadequate and/or inappropriate in light of his own total personality organization and the culture to which he belongs.

Specifically, in the United States mental illness has been classified by the Committee on Nomenclature and Statistics of the American Psychiatric Association for the use of physicians in whose province lies the responsibility for diagnosing illness.

See also Mental Health, Psychiatry.

Method: An orderly procedure or process; a manner of doing anything. For the purposes of this study, the word method will refer to the manner of instruction and evaluation; for example, lecture, small-group discussion, use of audio-visual aids, critical incident technique, et cetera. See also Evaluation, Teaching.

Milieu Therapy: A nonspecific phrase referring to treatment by means of modifying the environment in a hospital setting.[26] See also Therapeutic Community, Therapeutic Environment.

Nurse-Patient Interaction:[27] The purposeful, planned behavior of the nurse that has an effect or influence on the patient and that, in turn, is affected or influenced by the patient's response. Therefore, the nurse-patient interaction is a dynamic two-way process. The behaviors of the nurse and the patient combine to bring about mutual, although not necessarily similar, changes in the thoughts, feelings, and behaviors of the two persons. See also Nurse-Patient Relationship, Nursing Intervention.

Nurse-Patient Relationship:[28] An interaction process necessarily involving the nurse and the patient in fairly prolonged contact over a period of time. The nurse offers a series of purposeful activities and practices based on a body of theoretical and empirical knowledge, with the goal of fostering the patient's physical, social, and emotional well-being. This relationship differs from a social relationship, in which two persons interact primarily for reasons of pleasure or companionship, with neither person in a position of responsibility for helping the other.

The nurse-patient relationship takes place in the daily living situation in which the nurse and the patient find themselves and is consistent with the over-all treatment goal for the patient determined by the interdisciplinary team. It is not an end in itself, but rather a means through which (1) other aspects of nursing care are facilitated and can be made more effective and (2) the patient experiences a meaningful, healthy, satisfying interpersonal relationship, to the end that he may be able to transfer that which he has learned from this relationship to his relationships with others.

The goals of the nurse in a nurse-patient relationship are based on the needs of the patient and are designed to provide opportunities that will help the patient to grow emotionally. They include helping the patient to (1) maintain himself biologically; (2) identify, state, and meet his specific and concrete needs whenever possible; (3) clarify his feelings; (4) participate with others; (5) communicate with others; (6) increase his self-esteem; (7) increase his comfort and minimize his anxiety; and (8) test reality.

The nurse helps the patient to achieve these goals through the use of both verbal and nonverbal communication and by employing the following purposeful and planned attitudes and activities based on her knowledges and abilities: acceptance, respect, sensitivity, support, reassurance, encouragement, empathy, understanding, limit-setting, and consistency. The nurse deals only with conscious material and does not make dynamic interpretations of meaning to the patient. She focuses on strengthening areas of health. Emphasis is placed on current problems of the patient's living with others in the ward setting. The manner in which and the degree to which these attitudes and practices are implemented and manifested are determined to a great extent by the nurse's own unique personality and the degree of her self-understanding, self-acceptance, and educational preparation.

The nurse-patient relationship is artificially divided into three phases of development. In reality, these phases cannot be isolated, but tend to overlap.

The first phase is initiating the relationship. This phase is centered upon mutual attempts to know each other and to help the patient become oriented to his environment. The commencement of this phase is the responsibility and the function of the nurse, although in some instances the patient may take the initiative. Establishment of the foundations of acceptance and mutual trust is the predominant feature of this phase.

The second phase is continuing the relationship. The focus of this phase is on helping the patient to benefit from the interaction through the use of the attitudes, the activities, and the practices stated above.

The third phase is concluding or terminating the relationship. This phase is concerned with helping the patient to transfer his healthy modes of interaction from the nurse to others in his social milieu, both within and outside the hospital.

The nurse is supervised in this relationship, preferably by an experienced nurse with professional preparation.

See also Interaction, Interpersonal Relationship, Nurse-Patient Interaction, Nursing Intervention, Process Recording.

Nursing: One of the health occupations, which provides service to the individual, the family, and the community in health and in illness. The occupation of nursing includes several levels of practitioners: professional, technical, and vocational.[29] In addition, there is a group of semiskilled workers who assist the nurse in her practice.

Nursing as an *occupation* is an art and a science that requires the application of knowledge and the principles of biological, physical, and social sciences in the prevention of illness and in the treatment and rehabilitation of individuals in need of health services.[30]

The distinctive feature of nursing *practice* is the responsibility for doing for (or along with) a person, in whole or in part, that which he and/or his family ordinarily would do but are unable to do for a time or at all times.[31] This practice is directed toward identifying and meeting in varying degrees the physical, social, emotional, and spiritual needs of the individual, to the end that he is enabled to achieve or resume his position in society, function within the limitations imposed by his illness, or conclude his life-span as comfortably as possible.

There are seven areas of nursing function, the first six of which are *independent*:[32]

1. The supervision of a patient involving the whole management of [nursing] care, requiring the application of principles based upon the biologic, the physical, and the social sciences.
2. The observation of symptoms and reactions, including symptomatology of physical and mental conditions and needs, requiring evaluation or application of principles based upon the biologic, the physical, and the social sciences.
3. The accurate recording and reporting of facts, including evaluation of the whole care of the patient.
4. The supervision of [nursing personnel and the coordination of] others, except physicians, contributing to the care of the patient.

5. The application and the execution of nursing procedures and techniques.
6. The direction and the education to secure physical and mental care.

The one dependent area of nursing function is:[33]

7. The application and the execution of legal orders of physicians concerning the treatments and medications, with an understanding of cause and effect thereof.

In addition to the broad legal nursing functions outlined above, nursing also includes the following more specific functions:[34]

1. Ministering to the basic human needs.
2. Teaching self-care or counseling on health.
3. Participating in the patient's restorative activities in modification of daily living.
4. Planning with the patient for self-care, which is an outgrowth of managing the care for him--determining and timing the course of action and controlling the manner of its performance.
5. Communicating and interacting with the patient throughout all nursing functions--to give the patient opportunities to develop a sense of trust and a feeling of significance and ultimately of self-realization.

Nursing Care Plan:[35] A written evaluation of the patient's individualized nursing care needs, along with suggestions as to how these needs may best be met. Developing a nursing care plan is essentially a problem-solving process and requires that the nurse have ability to:

1. Identify the needs of the patient, including priorities of need.
2. Understand the possible reasons for the existence of these needs.
3. Identify appropriate nursing care, including priorities of care.
4. Understand how and why this nursing care may meet the patient's needs.

The nursing care plan is designed to guide the nurse in giving effective nursing care and is therefore developed prior to the administration of the care. However, the nursing care given on the basis of the initial nursing care plan is evaluated, and the plan is then revised accordingly. In fact, planning nursing care is an ongoing process subject to evaluation and revision as the needs of the patient change, as more information is gathered, and as greater depth of understanding of the patient is attained. Evaluation of the nursing care plan (reporting and describing the nursing care given and the patient's responses) forms the essence of the nurse's notes.

Contributions to the nursing care plan are made by all nursing personnel concerned with the care of the patient, taking into consideration the total plan of care developed by the interdisciplinary team. The use of the nursing care plan by all nursing personnel facilitates communication and continuity of patient care.

Although the nurse and the nursing team may increase their knowledge about a specific patient and their skill in rendering nursing care through the use of a nursing care plan, a nursing care plan is not essentially a teaching tool, but rather, a device designed to help in the provision of consistently effective nursing care to patients. Therefore, it is appropriately used in all instances in which a patient is in need of nursing care services.

See also Problem-Solving.

Nursing Intervention: The purposeful, individualized, planned activity of the nurse designed to help the patient regain psychophysiological homeostasis in a specific crisis situation associated with his illness. This crisis situation is a result of a psychophysiological disequilibrium caused by either internal or external forces with which the patient cannot cope unaided.

In psychiatric nursing, nursing intervention--the purposeful, individualized, planned activity of the nurse--is designed to help the patient deal with an increase in anxiety engendered by a specific crisis situation associated with his illness. This crisis situation can be a result of either increased intrapsychic conflicts or environmental forces with which the patient cannot cope unaided.

See also Nurse-Patient Interaction, Nurse-Patient Relationship.

Nursing Problem: A condition presented by the patient reflecting a situation faced by him or his family with which the nurse can assist him or them through the performance of nursing functions and activities.[36] Nursing problems need to be differentiated from the problems of the nurse and the patient's medical diagnosis. Although all three are closely related, only a statement of the nursing problem provides direction for determination of nursing functions and activities.

For example: The basic nursing problem of Patient A is:
To promote the development of productive interpersonal relationships.

Patient A's specific problem is:
Patient consistently remains by himself in a corner of the dayroom.

In contrast, the nurse's problem is:
Patient A does not agree to join the nurse and other patients in a group activity, and his medical diagnosis is schizophrenia.

See also Nursing Care Plan, Problem-Solving, Process Recording.

Philosophy: The beliefs through which man tries to understand himself and the world in which he lives. In relation to education, these beliefs underlie and provide the rationale for the goals of the educational process and for the methods used in the attainment of these goals.[37]

Principle: A specific statement of a theory involving a chain of concepts of the form "If A, then B." Serves to establish connection between different phenomena.[38]

See also Concept, Problem-Solving, Theory.

Problem-Solving: A kind of learning by means of which principles are put together in chains to form "higher order principles." These become the generalizations that enable the student to think about an ever-broadening set of new problems. Requires the prelearning of concepts and principles, and is manifested by the student's ability to propose and evaluate a solution to a new problem.[39]

See also Concept, Principle.

Process Recording: An exact written account of the verbal and nonverbal interaction between the nurse and the patient during a specified period of time. It includes an objective account of what the patient said and did and what the nurse said and did. This is followed by an analysis of what the nurse believes to have been the meaning of the interaction, including her feelings and those that she thinks the patient may have experienced.

It is helpful if the process recording is written in columns, as this format facilitates appreciation of both the vertical and the horizontal association of aspects of the interaction. In addition, sufficient space should be allowed for the instructor to write comments.

It is mandatory that a process recording be not only reviewed by the instructor but also discussed with the student on an individual basis in conference.

A process recording is written as soon after the interaction as possible in order to minimize the margin of error. It is rarely written during the interaction. This is not to say that the fact that process recordings are being kept should be hidden from the patient, but rather, that the nurse should be free from all distractions during the interaction. The patient needs to be assured both verbally and by her manner that the nurse will abide by the principles of confidentiality.

A well-done process recording is very valuable in helping the nurse to identify themes in both her behavior and that of the patient. Also, it helps the nurse to evaluate the progress of the nurse-patient relationship and to plan for its continuation. Each process recording can provide one basis upon which the over-all nursing care plan is revised in preparation for the next interaction with the patient.

As a teaching-learning tool, the process recording is useful in learning dynamics of human behavior, interpersonal relations, communication skills, self-awareness, et cetera, and can be useful in any nurse-patient interaction at any point in the curriculum. The use of this tool can commence with the first clinical nursing course but in the form of simple records of the interaction, known as interaction notes.

If the student had experience with interaction notes when studying nurse-patient interactions prior to the course or unit in nursing care of the mentally ill, she should be quite adept at executing the mechanics of the process recording when studying the nurse-patient relationship in the course or unit in nursing care of the mentally ill.

The most extensive use of the process recording will most likely be in the course or unit in nursing care of the mentally ill, since the primary focus of this course or unit is the interaction process. In addition, at this time the student will acquire a greater depth of knowledge about behavior, which will enable her to analyze the interaction more accurately and in greater depth than she had previously been able to do.

Prior to the use of this tool, its purpose should be thoroughly explained to the student and its use should be clearly related to the objectives of the experience. Purposeful or inadvertent censoring of the record by the student cannot, in most instances, be prevented. However, this should not be the cause of undue concern to the instructor, since the recognition by the student of what might have been a more appropriate response or behavior on her part indicates that learning must have taken place. Undue pressure on the student to be "right" at all times can be avoided to some degree if the process recording is not graded.[40]

See also Nurse-Patient Relationship, Nursing Care Plan, Nursing Problem, Problem-Solving.

Psychiatric Nursing: The field of nursing in which the major therapeutic goal of nursing care provided to patients is the promotion of mental health (which see), the prevention and the detection of mental illness (which see), and the treatment and the rehabilitation of patients with psychiatric disorders.

In providing such care, the function of the nurse is not different in nature from nursing in other clinical fields, but it does differ in its primary focus on interpersonal one-to-one and group relationships.[41]

More specific functions of the nurse include:[42]

1. Creating a therapeutic environment (which see)--acceptance, understanding, and provision of opportunities for the patient's emotional growth.
2. Studying the ward social structure in order to promote healthy socialization.
3. Establishing relationships with individual patients.
4. Establishing relationships with groups of patients.
   a. Structured or formal groups (patient government meetings, remotivation, activity groups, et cetera).
   b. Unstructured or informal groups (spontaneous discussions, et cetera).
5. Intervening in crisis situations.

The general goal of psychiatric nursing is to help patients to accept themselves and improve their relationships with other people.[43]

The field of psychiatric nursing includes several levels of practitioners--the professional psychiatric nurse (clinical specialist), the professional nurse, the technical nurse, and the vocational nurse--all of whom work with patients who are mentally ill. In addition, there is a group of semiskilled workers who assist the nurse in her practice.[44] For the purposes of this study, beginning first-level practice in psychiatric nursing shall be referred to as nursing care of the mentally ill, so as to differentiate technical-level practice.

See also Nursing.

*Psychiatric-Mental Health Nursing Content: For purposes of this study, psychiatric-mental health nursing content is considered to be the knowledges that are related to the understanding of individual and group behavior. These knowledges are based on the psychosocial sciences, the biophysical sciences, and psychiatry. When applied in the practice of nursing, these knowledges are manifested in the ability to engage in nurse-patient interactions, nursing interventions, and the nurse-patient relationships (which see), on both an individual and small-group basis. Inextricably involved in all of these abilities are communication and/or interviewing skills, skills in environmental modification, and appropriate attitudes in giving nursing care to all patients; i.e., both the physically ill and the mentally ill. Therefore, psychiatric-mental health nursing content is part of all nursing content. See also Communication, Integration, Therapeutic Environment.

Psychiatry: That specialized body of medical knowledges and skills that is primarily concerned with the study, prevention, diagnosis, and treatment of abnormal behavior in human beings.

Relationship: The state of being mutually or reciprocally interested or influential, thereby being connected.

Skill: A mode of operation and generalized technique for dealing with a problem. Little or no specialized and technical information is required. Although a skill can be learned, its mastery is more dependent upon natural endowment and experience than upon formal education. A skill may also be referred to as an art.[45] See also Ability, Knowledge.

Supportive Nursing Care: For the purposes of this study, supportive nursing care is the behavior of the nurse, based on the process of problem-solving (which see), in which she meets the needs of the patient in a manner that encourages the growth of the healthy aspects of his personality and minimizes the pathological aspects; i.e., she reinforces his current healthy defenses. The primary focus of supportive nursing care is to assist the patient to utilize more fully current effective patterns of behavior, as differentiated from focusing primarily on behavioral manifestations of the patient's psychopathology. See also Beginning First-Level Practitioner in Nursing Care of the Mentally Ill, Nurse-Patient Interaction, Nurse-Patient Relationship, Nursing Intervention.

Teaching: The imparting of knowledges and techniques through a variety of means both directly (example: instruction) and indirectly (example: role model) in any setting in which there is a recipient (learner). Implies not only instruction but also stimulation, encouragement, and guidance of the student by the teacher.[46]

Although the development of abilities, appreciations, and attitudes (which see) may be an indirect result of the teaching process, these cannot be directly taught, since their acquisition is dependent upon the capacity of the student to analyze, integrate, evaluate, and internalize his experiences.

See also Integration, Learning

Technical Occupation: A vocation requiring skillful application of a high degree of specialized knowledge together with a broad understanding of operational procedures; involving the frequent application of personal judgment; usually dealing with a variety of situations; and often requiring the supervision of others. It offers the opportunity for the worker to develop an ever increasing personal control over the application of his knowledge to his work and usually requires fewer motor skills than a trade or a skilled occupation and less generalized knowledge than a profession.[47] See also Beginning First-Level Practitioner.

*Terminal Expected Competency: The description of the desired outcome(s) of a program of studies, a course, or any given learning experience. It is stated in behavioral terms describing the expected performance of the student that has been established as the minimal acceptable level of achievement at the end of a planned unit of instruction and indicating that the learner has achieved the objective(s); i.e., there has been a behavioral change in the student. It is derived from and consistent with the philosophy of the program.[48] The term terminal expected competency is used interchangeably with the term terminal behavior. See also Behavior, Entering Behavior, Expected Competencies, Level of Achievement.

Theory: A statement that explains invariable associations (laws). Cannot be proved by direct perception because it does not state anything that has been or can be observed, but rather, characterizes general patterns or regularities to which individual phenomena conform and by virtue of which their occurrence can be systematically anticipated.[49] See also Concept, Principle, Problem-Solving.

Therapeutic Community: A specialized form of the therapeutic environment (which see). It utilizes all the principles that underlie the latter and others as well.

Among the distinctive features of the therapeutic community are the following:

1. Patients are included in practically all information sharing processes on the ward.
2. Patients' opinions are included in decisions about other patients' readiness for such things as passes and discharges.
3. Such patient inclusion in a democratic community process is considered treatment.[50]

All therapeutic communities have in common emphasis on open communication and group interaction. The main focus of the treatment program in the therapeutic community is on a variety of group meetings in which the process of interaction between staff and patients goes on. Group therapy (formal) is only one part. Other examples are ward meetings and activity groups.

These various group meetings and the therapeutic community as a whole serve to enhance and support other forms of concurrent treatment.

Each person, patient, or staff member serves some therapeutic function. Therefore, the personalities of the patients and staff are very important and help to determine the uniqueness of each individual therapeutic community. In all, however, communication among staff is of prime importance in planning, implementing, and evaluating the therapeutic community and in avoiding serious professional and personal conflicts.

A therapeutic community is a concept of treatment based on the belief that the hospitalization of an individual does not remove him from society, but rather, places him in a different society that is subject to study and regulation. "It may expose the patient to exactly the same pressure and interaction as elsewhere, but more carefully, with better timing and a simultaneous opportunity to gain insight into the nature of his emotions and behavior."[51]

This concept points up the therapeutic value of social relationships, but implementation of this concept varies from therapeutic community to therapeutic community.

See also Milieu Therapy, Therapeutic Environment.

Therapeutic Use of Self:[52] The nurse's employment of her own unique personality in interactions with an individual patient or a group of patients, with the goal of helping to produce a beneficial effect on those involved. The nurse's therapeutic use of self is an integral part of the nurse-patient relationship.

That the effect of this interaction is potentially beneficial is based on the following assumptions:

1. Helping patients to change their behavior as one way of improving their intrapersonal and interpersonal relationships is an appropriate goal of psychiatric nursing.[53]
2. Changes in patient behavior occur as a result of emotional experiences.[54]
3. One way in which a patient has emotional experiences is through interactions with the nurse.
4. These interactions are beneficial only if the nurse manifests an attitude of acceptance toward the patient.[55]
5. The nurse cannot truly accept the patient unless she accepts herself.
6. Since the nurse is a unique individual with a personality that differs from the personality of any other individual, it is necessary for her to continually grow in self-awareness so that she may be self-accepting.

7. Self-awareness and self-acceptance enable the nurse to manifest behavior that is consistent with her thoughts and feelings.
8. Consistency of the nurse's thoughts and feelings with her behavior constitutes a therapeutic asset.[56]

See also Nurse-Patient Interaction, Nursing Intervention, Nurse-Patient Relationship.

Therapeutic Environment: A milieu designed to help patients develop a sense of self-esteem and personal worth, to improve their ability to relate to others, to help them learn to trust others, and to return them to the community better prepared to resume their roles in living and working.[57]

In order to be therapeutic, the patient's environment must be purposeful and planned. Aspects to be taken into consideration are: physical aspects--i.e., homelike colors, furniture, et cetera, and provision for privacy; personal aspects--i.e., provision for physical needs such as food, cleanliness, rest, safety, et cetera, and acceptance in a friendly, warm atmosphere; and social aspects--i.e., provision for interaction and communication among patients and personnel.

A therapeutic environment meets the basic needs of the individual and provides a testing ground for the patient for new patterns of behavior.[58] It is based on a sound basic understanding of psychodynamics by the staff.

A therapeutic environment respects the individuality of each patient and at the same time provides for participation in democratic group activity. Emphasis is placed on socializing activities, for which the patients are encouraged to take increasing responsibility. Free-flowing communication among patients and staff, among patients, and among staff is essential.

A true therapeutic environment cannot be achieved unless an atmosphere of acceptance and optimism prevails throughout the unit. Any serious personal or professional conflict between staff members must be recognized and dealt with.

The setting of limits is not inconsistent with the concept of the accepting, permissive, democratic atmosphere of the therapeutic environment, but rather, is an essential part of it and reflects the realities of living in a democratic society.

The environment can be said to be therapeutic only if the philosophy is consistently implemented over the period of time that the patient is in the hospital. Consequently, it can be seen that the major responsibility for providing a therapeutic environment rests with the nursing personnel, the group of workers who are in the closest continual contact with the patients.

Continual appraisal, evaluation, and modification are mandatory if the therapeutic environment is to be a dynamic living force that helps patients to move in the direction of health.

See also Milieu Therapy, Therapeutic Community.

Understanding: The power to render experience intelligible by bringing perceived particulars under appropriate concepts. Frequently manifested by the student's capacity to adapt and modify knowledge to a new experience. See also Concept.

Value: The internalized worth of a thing, a phenomenon, or a behavior.[59] Enables the individual to make moral judgments, which,in turn, provide the basis for his behavior. See also Appreciation, Attitude.

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APPENDIX C. PLANNING FOR INTEGRATION OF PSYCHIATRIC-MENTAL HEALTH NURSING CONTENT IN THE CURRICULUM AND FOR THE COURSE OR UNIT IN NURSING CARE OF THE MENTALLY ILL

CONCEPT: Man in Relation to Himself--Dynamics of Individual Behavior

I. PRECEDING THE COURSE OR UNIT IN NURSING CARE OF THE MENTALLY ILL

TERMINAL EXPECTED COMPETENCIES: Nurse-Patient Relationship	EXAMPLES OF CONTENT			LEARNING EXPERIENCES	TEACHING TOOLS AND METHODS	EVALUATION METHODS
	Knowledges	Skills and Abilities	Attitudes and Appreciations			
I. The student has an appreciation of herself both as a person with varying physical, psychological, and developmental needs and as a practitioner with responsibilities, potentialities, and limitations.			Self-awareness			
II. The student engages in a supportive relationship, as the need dictates, with a selected patient under the supervision of a nurse with broad professional preparation.						
A. Plans for the supportive relationship based on patient needs and nursing problems, using the problem-solving approach.	Human growth and development from birth through senescence: Freud, Sullivan, Erikson	Problem-solving Observation	Significance of human relationships			
1. Initiates contact with the patient.						
2. Assesses the patient's present and potential capabilities and goals, taking into consideration his limitations, both physical and emotional.			Worth and dignity of man			
3. Avoids labeling the patient.						
4. Writes a plan for the supportive relationship that is a part of the over-all nursing care plan.	Normal human behavior according to: Maslow, Freud, Sullivan	Identification of manifestations of normal human needs at all stages of growth and development				
5. Plans the supportive relationship so that it is part of the total treatment plan for the patient.						
B. Implements her plan for the supportive relationship.						
1. Establishes the supportive relationship.						
a. Orients the patient to the functions and purposes of the relationship, setting limits on the relationship.						
b. Begins consideration of plans with the patient for conclusion of the relationship.						
c. Identifies roles she assumes in the relationship.	Anxiety and defense mechanisms					
2. Continues the supportive relationship.						
a. Recognizes when the relationship is in the continuing phase.						
b. Recognizes her limitations and seeks appropriate assistance.	Conflict--frustration					
c. Recognizes that her feelings about the patient influence her behavior toward him, which in turn influences his behavior.	Ambivalence					
d. Identifies and accepts as not personally significant the patient's positive and negative verbalizations and behaviors.						
e. Exhibits positive attitudes toward the patient; e.g., she is:	Interrelatedness of psyche and soma; principles and examples of					
(1) Nonpunitive. (4) Permissive.						
(2) Nonjudgmental. (5) Empathic.						
(3) Accepting.						
f. Promotes the relationship through nursing actions based on the patient's needs; e.g.,	Stereotypes					
(1) Carries out individualized safety measures.	Cultural differences and similarities as related to behavior					
(2) Sets realistic limits for the patient.						
(3) Stays with or leaves the patient when this action would benefit him.						
(4) Is consistent in her behavior and attitudes.						
(5) Utilizes communication skills knowledgeably.	Theories of communication: Ruesch--verbal, nonverbal; Rogers; transactional					
(a) Is aware of the relationship between her communication and the response of others.						
(b) Is aware of the effect of her anxiety on her ability to communicate purposefully.		Listening				
(c) Attends to the communication of others.		Interviewing				
(d) Observes nonverbal communications.						
(e) Recognizes prominent themes in the communication of others.						
(f) Tolerates silence.						
(g) Keeps open the flow of effective verbal communication.						
(h) Validates the communications of others with them.						
(i) Is purposeful in her communications.						
(j) Is selective in her verbal response.						
(k) Limits her communication to discussion of the current situation.						

(l) Respects the principles of confidentiality. g. Recognizes the implications of signs of change in patient behavior; e.g.: (1) Level of anxiety. (3) Level of withdrawal. (2) Level of depression. (4) Level of hostility. h. Accepts the patient's progressive independence. i. Continually revises her plan for the relationship as needed (see item C below). j. Discusses those feelings about the patient that affect her nursing care with a nurse with broad professional preparation. 3. Concludes the supportive relationship. a. Follows through on plans previously made with the patient for conclusion of the relationship. b. Identifies and accepts her feelings of separation anxiety. c. Identifies and accepts the patient's feelings of separation anxiety as evidenced by his behavior. C. Evaluates her plan for the supportive relationship. 1. Identifies changes in patient needs and nursing problems on the basis of changes in the patient's behavior. 2. Determines the effectiveness of the relationship in terms of the goals of the relationship. 3. Accepts the patient's present and potential capabilities and goals, taking into consideration his limitations, both physical and emotional. 4. Recognizes and accepts her limitations in the relationship. D. Revises her plan for the relationship on the basis of the evaluation. 1. Supplements knowledges and skills as needed. 2. Seeks appropriate assistance.	Criteria of Mental Health: Marie Jahoda				

CONCEPT: Man in Relation to Himself--Dynamics of Individual Behavior

II. INCLUDED IN THE COURSE OR UNIT IN NURSING CARE OF THE MENTALLY ILL

TERMINAL EXPECTED COMPETENCIES: Nurse-Patient Relationship	EXAMPLES OF CONTENT			LEARNING EXPERIENCES	TEACHING TOOLS AND METHODS	EVALUATION METHODS
	Knowledges	Skills and Abilities	Attitudes and Appreciations			
I. The student has an appreciation of herself both as a person with varying physical, psychological, and developmental needs and as a practitioner with responsibilities, potentialities, and limitations.						
II. The student engages in a supportive relationship, as the need dictates, with a selected patient under the supervision of a nurse with broad professional preparation.* A. Plans for the supportive relationship based on patient needs and nursing problems, using the problem-solving approach.	Criteria of functional mental illness Dynamics of development of functional mental illness Causes of and precipitating factors in exaggerated behavior	Writes nursing care plan Differentiates between normal and abnormal behavior				
B. Implements her plan for the supportive relationship.	Role of anxiety in mental illness Somatic therapies--interrelatedness of psyche and soma Blocks in communication		Acceptance of behavior of mentally ill as manifestation of illness.			
C. Evaluates her plan for the supportive relationship.						
D. Revises her plan for the relationship on the basis of the evaluation.						

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*In the interest of saving space, only general headings are repeated.

CONCEPT: Man in Relation to Himself--Dynamics of Individual Behavior

III. FOLLOWING THE COURSE OR UNIT IN NURSING CARE OF THE MENTALLY ILL

TERMINAL EXPECTED COMPETENCIES: Nurse-Patient Relationship	EXAMPLES OF CONTENT			LEARNING EXPERIENCES	TEACHING TOOLS AND METHODS	EVALUATION METHODS
	Knowledges	Skills and Abilities	Attitudes and Appreciations			
I. The student has an appreciation of herself both as a person with varying physical, psychological, and developmental needs and as a practitioner with responsibilities, potentialities, and limitations.						
II. The student engages in a supportive relationship, as the need dictates, with a selected patient under the supervision of a nurse with broad professional preparation. A. Plans for the supportive relationship based on patient needs and nursing problems, using the problem-solving approach.	Psychophysiological manifestions of illness Behavior resulting from organic brain damage Neurotic reactions to physical illness					
B. Implements her plan for the supportive relationship. C. Evaluates her plan for the supportive relationship. D. Revises her plan for the relationship on the basis of the evaluation.	Application of previously learned knowledges, skills, and abilities in depth to the care of all patients with major health problems					

CONCEPT: Man in Relation to Others--Dynamics of Communication

I. PRECEDING THE COURSE OR UNIT IN NURSING CARE OF THE MENTALLY ILL

TERMINAL EXPECTED COMPETENCIES: Nurse-Patient Relationship; Working With Others	EXAMPLES OF CONTENT			LEARNING EXPERIENCES	TEACHING TOOLS AND METHODS	EVALUATION METHODS
	Knowledges	Skills and Abilities	Attitudes and Appreciations			
I. The student has an appreciation of herself both as a person with varying physical, psychological, and developmental needs and as a practitioner with responsibilities, potentialities, and limitations.			Significance of self as a therapeutic agent			
II. The student engages in a supportive relationship, as the need dictates, with a selected patient under the supervision of a nurse with broad professional preparation.						
A. Plans for the supportive relationship based on patient needs and nursing problems, using the problem-solving approach.	Characteristics of: nurse-patient interaction, nursing interventions in normal reactions to life situations	Nursing care plan				
B. Implements her plan for the supportive relationship.	Relationship between the behaviors of the patient and the nurse, and vice versa	Interaction notes Matheney's "Principles of Psychiatric Nursing'				
	Cultural differences among people	Communication skills	Acceptance of cultural differences			
C. Evaluates her plan for the supportive relationship.						
D. Revises her plan for the relationship on the basis of the evaluation.						
III. The student functions in group situations with patients, with the nursing team as a team member and also functions as such on the interdisciplinary team.	Types of groups Functions of groups Characteristics of groups--communication within groups		Appreciates function of groups in facilitating attitude change in individuals			
A. Is aware of her strengths and limitations and seeks appropriate assistance.						
B. Is aware of the possible effects of her own behavior on others in the group.						
C. Identifies her role as a nurse in the group.						
D. Maintains and interprets her role in the group.						
E. Assumes other appropriate group roles in the group.						
F. Contributes to the group by supplying information from her frame of reference.						
G. Considers the group needs in planning, initiating, and following through on group discussions and activities.	Group roles Group values Group norms--influence of social, cultural differences					
H. Utilizes unstructured group situations to engage the group in activity or discussion toward planned ends.						
I. Cooperates with and contributes to the total functioning of the group.						
J. Communicates purposefully in her interactions in the group.						
K. Appreciates the possible effects of each group member on others in the group.						
L. Identifies constructive and destructive group interaction.	Theories of small-group behavior: constructive and destructive	Simple sociometric technique				
M. Supports constructive interaction among group members.						
N. Intervenes in destructive group interaction directly or by seeking appropriate assistance.						
O. Discusses her feelings about the group with the group and/or with a nurse with broad professional preparation.	Role of individual within groups		Appreciates needs of individual members			
	Characteristics of: family groups, patient groups, nursing	Health teaching with small groups of "normal"				

II. INCLUDED IN THE COURSE OR UNIT IN NURSING CARE OF THE MENTALLY ILL

EXAMPLES OF CONTENT			LEARNING EXPERIENCES	TEACHING TOOLS AND METHODS	EVALUATION METHODS
Knowledges	Skills and Abilities	Attitudes and Appreciations			
Characteristics of phases of nurse-patient relationship	Writes a plan for the nurse-patient relationship as part of the nursing care plan				
Roles of the nurse according to: Peplau, Matheney	Writes process recordings	Accepts patient's positive and negative verbalizations and behaviors as not personally significant			
Symbolization and desymbolization					
Patient safety					
Remotivation techniques (SKF)	Uses problem-solving in planning for and conducting patient group meetings	Appreciates possible effect of her own behavior on others in group situation			
Leadership roles that facilitate communication within group and help to keep discussion focused					

III. FOLLOWING THE COURSE OR UNIT IN NURSING CARE OF THE MENTALLY ILL

EXAMPLES OF CONTENT			LEARNING EXPERIENCES	TEACHING TOOLS AND METHODS	EVALUATION METHODS
Knowledges	Skills and Abilities	Attitudes and Appreciations			
Application of previously learned knowledges, skills, and abilities in depth to the care of all patients with major health problems					
Team nursing		Appreciates her role as a member of both the nursing team and the interdisciplinary team			
	Assumes appropriate group role in various group situations				

CONCEPT: Man in Relation to the Environment--Dynamics of Environmental Influences

I. PRECEDING THE COURSE OR UNIT IN NURSING CARE OF THE MENTALLY ILL

TERMINAL EXPECTED COMPETENCIES: Therapeutic Environment	EXAMPLES OF CONTENT			LEARNING EXPERIENCES	TEACHING TOOLS AND METHODS	EVALUATION METHODS
	Knowledges	Skills and Abilities	Attitudes and Appreciations			
IV. The student contributes to the establishment and maintenance of a therapeutic environment. A. Considers in her nursing care plan the effect of the immediate environment on the patient. B. Is aware that health workers have an influence on the environment. C. Identifies disruptive and therapeutic factors in the environment. D. Initiates modifications in the immediate environment of assigned patients when needed and when possible. E. Carries out safety measures.	Definition of environment including: physical aspects, psychosocial aspects, immediate and long-range aspects Characteristics of a therapeutic environment	Identifies disruptive and therapeutic factors	Appreciates effect that attitudes of health workers have on the environment			

II. INCLUDED IN THE COURSE OR UNIT IN NURSING CARE OF THE MENTALLY ILL

EXAMPLES OF CONTENT			LEARNING EXPERIENCES	TEACHING TOOLS AND METHODS	EVALUATION METHODS
Knowledges	Skills and Abilities	Attitudes and Appreciations			
Current philosophies of psychiatric care: Social therapies Effects of hospital and immediate environment on patient; e.g., covert expectations conveyed by staff attitudes					

III. FOLLOWING THE COURSE OR UNIT IN NURSING CARE OF THE MENTALLY ILL

EXAMPLES OF CONTENT			LEARNING EXPERIENCES	TEACHING TOOLS AND METHODS	EVALUATION METHODS
Knowledges	Skills and Abilities	Attitudes and Appreciations			
Application of previously learned knowledges, skills, and abilities in depth to the care of all patients with major health problems					

APPENDIX D. PARTICIPATING PROGRAMS

Diploma Schools

Alexandria Hospital
School of Nursing
Alexandria, Virginia

Lillie Jolly School of Nursing
Memorial Baptist Hospital
Houston, Texas

Marion County General Hospital
School of Nursing
Indianapolis, Indiana

Mount Sinai Hospital
School of Nursing
New York, New York

Oak Park Hospital
School of Nursing
Oak Park, Illinois

O'Connor Hospital
School of Nursing
San Jose, California

St. Joseph Hospital
School of Nursing
Tacoma, Washington

Associate Degree Programs

Clark College
Department of Health Education Occupations
Vancouver, Washington

Gwynedd Mercy College
Department of Nursing
Gwynedd Valley, Pennsylvania

Henry Ford Community College
Nursing Division
Dearborn, Michigan

Manatee Junior College
Department of Nursing
Bradenton, Florida

Orange County Community College
Department of Nursing
Middletown, New York

Ricks College
Department of Nursing
Rexburg, Idaho

Sacramento City College
Associate Degree Program in Nursing
Sacramento, California

Vermont College
Department of Nursing
Montpelier, Vermont

APPENDIX E. CONSULTANTS TO THE PSYCHIATRIC NURSING PROJECT

Advisory Committee to the Project

Chairman*

Mrs. Lorene Fischer (1965-1968)
Associate Professor of Nursing
Wayne State University
Detroit, Michigan

Members

Mrs. Lucille V. Bailey, Instructor
Psychiatric Nursing
Rochester State Hospital
Rochester, New York

Dr. Joan M. O'Brien, Assistant Dean
for Graduate Programs
University of Florida College of Nursing
Gainesville, Florida
now
Dr. Joan O'B. Hartigan, Dean
College of Nursing and
Director, Nursing Services
Downstate Medical Center
State University of New York
Brooklyn, New York

Sister Immaculata Hayes, Supervisor-
Instructor, Psychiatric Nursing
St. Marys Hospital School of Nursing
Rochester, Minnesota

Dr. Mary F. Liston, Chief Investigator
of the project and former Director
NLN Division of Nursing Education
now
Dean, School of Nursing
The Catholic University of America
Washington, D. C.

Louise G. Moser, Chairman
Department of Nursing
Mesa Junior College
Grand Junction, Colorado

Marie A. Warncke, Associate
Director in Charge of Nursing
Education
Greenville General Hospital School
of Nursing
Greenville, South Carolina

NLN Staff

Katherine Brim, Assistant Director
Department of Diploma Programs

Margaret Collins, Assistant Director
Department of Associate Degree Programs

Gerald Griffin, Director
Department of Associate Degree Programs

Frances K. Peterson, Director
Department of Diploma Programs

Dr. Barbara L. Tate, Director
Division of Research and Development

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*First chairman (1963-1965): Mary Redmond (deceased), Acting Director, School of Nursing, The Catholic University of America, Washington, D. C.

Consultants in Associate Degree Nursing Education

Fundamentals of Nursing

Breda Nolan, Associate Professor
Department of Nursing
Nassau Community College
Garden City, New York

Maternal & Child Health Nursing

Mrs. Dorothy C. Stratton, Instructor
Department of Nursing
Daytona Beach Junior College
Daytona Beach, Florida
now
Associate Professor and Chairman
Department of Maternal-Infant Nursing
School of Nursing
Medical College of South Carolina
Charleston, South Carolina

Nursing in Physical Illness

Margaret Scanlon, Instructor
Department of Nursing
Bronx Community College
Bronx, New York

Psychiatric Nursing

Mrs. Geraldine Brown, Instructor
Department of Nursing
Queens College
Flushing, New York
now
Lecturer, Nursing Science Program
Queens College

Consultants in Diploma School Nursing Education

Fundamentals of Nursing

Nancy Lou Johnson, Instructor
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Methodist Hospital
Madison, Wisconsin
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Department of Curriculum & Instruction
University of Wisconsin
Madison, Wisconsin

Maternity Nursing

Mrs. Ruth A. Nicholson, Instructor
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Greenville General Hospital
Greenville, South Carolina

Medical-Surgical Nursing

Sister Maureen, Instructor
School of Nursing
St. Marys Hospital
Rochester, Minnesota

Nursing of Children

Joan Williams, Instructor
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Gainesville, Florida

Psychiatric Nursing

Mrs. Sylvia Edge, Instructor
School of Nursing
St. Francis Hospital
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Instructor in Nursing
Middlesex County College
Edison, New Jersey

Consultants in Psychiatric Nursing

Sister Kathleen M. Black, Professor
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The Catholic University of America
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Doris Haid, Project Director
Wayne State University College of Nursing
Detroit, Michigan
now
Chairman, Instructional Program in Psychiatric Nursing for Hospital Diploma Students
Wayne State University College of Nursing

Marguerite Holmes, Supervisor
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now
Associate Professor, Nursing Education
Illinois State Psychiatric Institute

Ruth V. Lewis, Director
Mental Health Nursing
Greater Kansas City Mental Health Foundation
Kansas City, Missouri

Mary V. Topalis, Chairman
Department of Nursing
Fairleigh Dickinson University
Rutherford, New Jersey
now
Dean, College of Nursing
University of Bridgeport
Bridgeport, Connecticut

Sister Edith Tuberty, Assistant Professor
College of St. Catherine Department of Nursing
St. Paul, Minnesota
now
Clinical Specialist in Psychiatric Nursing
St. Joseph's Hospital
St. Paul, Minnesota

Gertrud Ujhely, Director
Graduate Program in Psychiatric Nursing
Adelphi University School of Nursing
Garden City, New York
now
Associate Professor and Director
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Adelphi University School of Nursing

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Clinical Associate in Nursing
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Teachers College, Columbia University
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Wallace Mandell, Ph.D.
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Staten Island Mental Health Society
Staten Island, New York

Harry Martin, Ph.D.
Associate Professor of Psychiatry
University of Texas Southwestern Medical School
Dallas, Texas

Mary M. Redmond (deceased)
Acting Dean, School of Nursing
The Catholic University of America
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Gertrud Ujhely, Director
Graduate Program in Psychiatric Nursing
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now
Associate Professor and Director
Graduate Program in Psychiatric Nursing
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Margaret M. Wright
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Embreeville, Pennsylvania
now
Doctoral candidate
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Philadelphia, Pennsylvania